

IDAHO STATE VETERANS – POCATELLO
NURSING PROCEDURE MANUAL

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I ACTIVITIES

ACTIVITY PLANS

Each resident will have a Care goal-orientated Plan developed within 14 days of admission as standard procedure. The resident is interviewed by the activity coordinator or designee and assessed for his/her activity preferences resident. Care Plans will be updated quarterly and PRN.

Scheduling of Activities

The activity coordinator plans activities for each month. The activity aide then carries out the plan as designed. Schedules are developed prior to the last week of the month for the following month. Calendar boards are maintained by activity aide or activity coordinator. These are changed the first working day of each month.

Procedures for Group Activities

Activity schedule is discussed with activity staff each morning and relayed to facility leadership following.

Birthdays

Birthday decorations are the responsibility of the activity aide. This may include an individual birthday recognition poster, balloons etc. Birthday cakes are provided by American Legion Auxillary and distributed by Dietary Staff.

Individual Activities

One-on-one activities are scheduled as frequently as possible according to the individual's care plan. The activity aide should schedule these activities in between scheduled group activities.

Purchasing/Budget

Budget is limited to monthly disbursement through IVAL to be utilized by the Activity Coordinator.

Progress Notes/Activity Assessment

Quarterly Progress Note and Activity Assessment charting is to be completed on each resident on a rotating basis. Plans are reviewed and, if necessary, a request for modification is referred to the activity coordinator for revision. A record of each resident's participation/, nonparticipation, is documented and their goals are addressed.

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Protocol for dress code while on activity outings

If a staff member is assigned to an activity on a “paid basis”, the staff should check with the activities aide for proper attire. At all times, the attire will be neat, clean and appropriate, as you will be representing our facility to the public. Pertinent examples may include:

1. Fishing trip: jeans
2. Fair or rodeo: jeans
3. Community sponsored days: uniform
4. Shopping trips: uniform
5. One-to-one trips to restaurants, picnics, van rides: uniform.

Protocol for dress code for specialty days during calendar year.

On designated days during the year, the Activities Committee will request that you participate by wearing appropriate attire as specified. We do this for two reasons:

1. To develop a respite for our residents from the day-to-day task-oriented routine we must adhere to. They enjoy seeing staff “out of uniform.”
2. To promote a feeling of comradeship within the facility. On these days, we attempt to deviate from routines and give the residents more choices in their scheduled events.

On a daily basis, In support of our dress code, we expect you will be neat, clean and appropriately attired.

Reviewed 01/15

Protocol for one-on-one time with debilitated/disabled residents.

Identify those residents who are unable to join in regularly sponsored and scheduled activities.

Consult plan of care to determine deterrents (health wise) to any activity that might be scheduled for them. If uncertain at that point consult with Charge Nurse.

When possible and/or feasible, activities will be scheduled outside the facility. This may be simple, such as a picnic in the park, a van ride or a walk on the ISVH grounds. This change in environment and setting may stimulate sensory responses.

Family can be included in planning the activity when possible. Information may be solicited on what resident has enjoyed in the past. While on the outing, staff will make note of resident responses and, when possible, relay to family members.

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Spend a little time listening to family members if resident is non-communicative. If information is shared which may be perceived as confidential, contact social services for intervention, without divulging information.

Staff will document activity in Participation note which will give insight into problems encountered, solutions tried and ideas for future activities. If a behavior is noted, it will be documented in Behavior Charting in PCC.

Revised 01/15

PROTOCOL FOR PET THERAPY

Residents are not allowed to have pets living in the facility, however, their family members may bring their pet to visit. All pets that enter the Home must have proof of vaccinations. Questions about pet visits should be directed to the Activity Department.

Pet therapy will be an activity for the residents at ISVH, sponsored and monitored by activities.

In addition, family members may bring in pets to the activity room area or patio areas, which have been properly vaccinated. Pets, on a leash, may be brought to units when accompanied by activity aides, during specified pet therapy.

Revised 01/15

II ADMINISTRATIVE

ALERT CHARTING

This procedure is a process to ensure a resident's acute situation/condition is assessed and documented in the medical record (PCC)

Areas to Monitor / Observe / Assess

Pain- description of pain (aching, stabbing, throbbing, burning) location, constant/intermittent, severity. **Edema-** Site, pitting or non-pitting. **Heart Sounds-** Rate, rhythm resident, Symptoms- syncope, fainting, flutters. **Central Nervous System-** Change in function, weakness, paralysis, spasticity, flaccidity, description of extremity affected. **Responsiveness-** any changes, responses to pain, eyes open or closed, restlessness, etc. **Gastro-intestinal-** Nausea/vomiting, diarrhea – description of interventions, medications administered. **Gastro-urinary-** Pain/description, urinary frequency, urgency, change in continence, color, odor, sediment. **Musculo-Skeletal-** Pain/ description, change in level of mobility, medications administered. **Respiratory- Lung** sounds, nature of respirations, cough-productive, congested, hydration, and amount of intake. **Fever-** Medications, medication given, assessment.

1. **An order will be written:** to document the assessment when one or more of the following resident situations/conditions occurs.
 - a. **New admit-** Q shift x 7 days. If **new** issues develop implement a new **specific** alert charting order.
 - b. **Fall or other incident-** Q shift + VS X 72 hours (assess for new pain, bruising, other injuries, mental status, changes from baseline/ NEURO checks if head is involved or was unwitnessed, changes of gait and the preventative measures that are in place.
 - c. **Change of condition-** X 72 hours or duration of illness if longer, as appropriate.
 - d. **Seizures-** 24 hours after last seizure –VS Q shift (complete NEURO checks)
 - e. **Change/ new medication-** (NON-PSYCHOTROPIC) Q shift x 72 hours – S/S of adverse side effects, effectiveness of medication.
 - f. **Change/ new Psychotropic medication-** Q shift X 14 days- any changes in behavior, change of mental status or cognition.

2. **Order must include:**
 - a. Reason for assessment.
 - b. Area/ situation to be assessed.
 - c. Time/ shifts to be documented and assessed. (set in PCC to come up for documentation)
 - d. END DATE: (based on above suggested time frame) MUST HAVE END DATE.
 - e. Document assessment using the "ALERT CHARTING PROGRESS NOTE" (drop down) in PCC.

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3. **Nurse responsible for implementing** "Alert Charting Order" is the nurse identifying the resident acute situation/condition.
4. All alert charting is added to the Alert Charting Daily sheet found in the nursing (n) drive in the charge nurse folder and printed out for the medication nurses.
 - Alert Charting will be updated every NOC shift by the charge nurse and printed out for every incoming medication nurse so they know who to chart on.,.
 - Charge nurse will print out a copy of the alert charting for every oncoming L.P.N. so they will know who to chart on.
 - Please put a copy in the DNS box as well.

References:

- a. Centers for Medicare & Medicaid Services, U.S, Department of Health and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities.* (June 2016 Revision) *Unnecessary Drugs* 483.25(1)
- b. Centers for Medicare & Medicaid Services, U.S, Department of Health and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities.* (June 2016 Revision) *Mental and Psychosocial Functioning* 483.25(f)(1)&(2), F319, F320
- c. Centers for Medicare & Medicaid Services, U.S, Department of Health and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities.* (June 2016 Revision) *Unnecessary Drugs* 483.4(c)(3),(e)(d)

Revised 02/18, 11/2019, 5/2020

CREDENTIALING AND PRIVILEGING

Credentialing

Credentialing is the process of obtaining, verifying and assessing the qualifications of a health care practitioner who may provide resident care services in or for a health care organization. This is to ensure that the health care provider is who s/he says s/he is and has done what s/he says s/he has done and have the credentials s/he represents him/herself to have. The list includes physician, podiatrists, psychologist, physician assistants, nurse practitioners, and licensed nurses.

Privileging

Privileging is the process whereby a specific scope and content of resident care services are authorized for a health care practitioner by the facility management, based on evaluation of the

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individuals' credentials and performance process by which the scope of practice of each health care practitioner is defined and scope of care that may be provided by the practitioner and/or what care may not be done.

Credentialing and Privileging Process – Committee

1. Credentialing and Privileging Committee shall meet no less than annually and when a new provider petitions to provide treatment and/or in-services to our resident(s).
2. The Committee shall consist of the facility Administrator, Medical Director, Director of Nursing Services, Health Information Manager, and other interested parties.
3. A person on the committee shall be designated as responsible for periodically checking with the HHS 01G List of Excluded Individuals and Entities for all of its employees and contractors. (<http://exclusions.oig.hhs.gov/search.html>) (See applicable form.)
4. Minutes of the meeting(s) shall be recorded and maintained by the facility Administrator.

Credentialing Procedure

1. The following core criteria shall be maintained on each provider:
 - a. Current license (verification may be done either on-line through the state's professional licensing/regulatory board, a secondary source site, or a copy of the provider's license).
 - i. The license must be current.
 - ii. The license should be unrestricted. Any restriction must not interfere with the provider's ability to perform within the scope of their license.
 - b. A Licensure History or Self-Attestation should be completed. (See applicable forms.)
 - c. Current certification, if applicable.
 - d. Relevant education, training, and experience.
 - e. Current competencies.
 - f. A statement that the individual is able to perform the services s/he is applying to provide; e.g., "John Doe does not have a physical or mental health condition that would adversely affect the applicant's ability to carry out the clinical duties as a primary physician."
2. Other licensed personnel providing care to the residents such as registered nurses and licensed practical nurses will have a scope of practice statement included in the Job description and on file in their personnel record.

Privileging Procedure

1. Based on evaluation of the provider's credentials and performance, the committee will authorize a specific scope and content of resident care services.

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2. When the facility's Medical Director also provides care and treatment to the home's residents, the Home Administrator and remaining members of the committee will privilege the Medical Director in accordance with the credentialing criteria listed above.
3. The following are examples of privileging statements/scope of practice statements:
 - a) The **physician** is allowed to admit, treat, discharge and transfer patients to hospital, perform histories and physical, prescribe medications including narcotics, perform routine and minor invasive procedures.
 - b) The **podiatrist** is allowed to work under the direct referral of a referring physician including doctors of osteopathy, perform routine and minor invasive procedures.

Upon completion of the above process/procedure, the facility's Administrator shall notify each provider, in writing, of the committee's decision.

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Procedures For Doctors Visits, Dental Visits, Or Other Medical Appointments

When possible medical appointments should be scheduled when routine duties can be assumed by other personnel.

Individuals who schedule non-emergency medical appointments at high priority times of the day may be asked by unit managers to reschedule their appointments.

On-call/temporary personnel will be expected to schedule non-emergency medical appointments to occur on their off days. However, on-call/temporary personnel may be granted for time off for medical appointments during scheduled work hours, on special occasions, with supervisor approval.

All employee and family emergencies will be treated as high priority and will be dealt with accordingly.

Revised 01/15

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PROCEDURE FOR HANDLING EXCESSIVE USE OR SUSPECTED ABUSE OF SICK TIME

The RN Manager in consultation with the Director of Nursing will monitor patterns of employee sick time usage where excessive use or abuse is suspected.

A Manager shall have reasonable cause for suspicion if an employee uses all sick time as it is accrued or a pattern for usage can be established.

If any employee uses all sick time as accrued or demonstrates a pattern of calling in prior to or following days off or primarily weekends, the RN Manager and/or Director of Nursing will verbally counsel that employee to discontinue such practice. If the pattern continues, a written reprimand will be given to the employee. If, following verbal counseling and a written reprimand, the employee continues the excessive use or abuse of sick leave, further disciplinary action may be taken up to and including termination.

Surgery, injuries, or documented illnesses will not be counted as, or termed to be excessive usage of sick time.

Reviewed 01/15

TARDY ATTENDANCE

The following is protocol for tardy behaviors regarding Licensed/Certified staff.

1. It is expected for you to be within the facility and ready for report at the time indicated on your schedule.
2. Individuals arriving to work 7 minutes after the hour will be considered "tardy". The names of individuals arriving to work late will be documented in the "Call-in" book with the time of arrival. This will be documented by the charge nurse.
3. Individuals arriving to work more than 45 minutes late will be documented the same. This occurrence will be directly communicated to the RNM or DNS, via email or phone, for further investigation.

03/2019

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CALL-IN PROCEDURE

The following is protocol for calling when you are unable to report for work. Nurse Aides are not authorized to accept call-ins.

1. It is expected that you, personally, notify the facility of your absence at least two (2) hours prior to the beginning of your scheduled shift. Calls from family members, etc., will not be accepted unless the employee is incapacitated. It is not acceptable for the employee to leave a voice mail, you must talk with the Charge Nurse at 208-235-7848.
2. The LN taking the call, or RNM can request a physician's excuse from the employee.
3. When a call-in is received, the Charge Nurse taking the call will document the information in the "Staff call in book". The Charge Nurse will ask the employee what is wrong and will be expected to document the reason for absence such as Fever, Nausea, Vomiting, URI etc. This is especially important for the employee infection control purposes. The Charge Nurse will then document on the nursing schedule and cover the shift. If unable to replace staff, and the minimum staffing is not met, the RNM and/or DNS are to be notified to help problem solve.
4. The "Staff Call in Book" information will be routed to the RN Manager and/or the DNS who will then document on the employee record.
5. In the case of an employee not showing up for work, (no call no show, NCNS), the Charge Nurse on duty will try to make contact with the employee to determine the reason for the employee not reporting to work as scheduled. When this occurs the Charge Nurse will report this to the RNM or DNS and attempt to fill the employee's shift. The RNM or DNS will continue to make every effort to contact the employee. It is the responsibility of the RNM or DNS to determine if this is an excused absence or unexcused absence. If the employee has two or more unexcused absences due to NCNS then disciplinary action up to and including termination may be implemented.

Revised 08/15, 03/19

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EMPLOYEE I-Time sheets and Staff worksheet assignment

Employees are to daily put correct time worked in I-time and save. After the final day worked in a pay period the I-time should be submitted. The employee "sign-in" book is used to communicate with staff and used for staff who do not have access to I-time.

Nursing staff employees shall check the Daily Sign in Worksheet for the unit assigned and work to complete assigned duties.

The Health Information Specialist will review the Staffing Schedule and Worksheet for completeness, accuracy, adherence to facility staffing policies, procedures, and practices.

The HIS will determine accuracy of the I-time on a daily basis and will tabulate the worksheet for actual nursing hours for the 24 hour period.

Revised 06/16

LABORATORY TEST RESULTS NOTIFICATION

Purpose

To provide a process to timely notify a resident's physician/medical provider of laboratory test results.

Procedure

Critical Lab Values:

1. The laboratory contract provider will call the facility with any critical lab values.
2. Upon receipt of information regarding critical lab values, the charge nurse or designee will immediately contact the resident's physician/medical provider for further instructions/orders. A nursing note will be written in the progress note by the charge nurse or designee regarding the notification of the physician. The note must address the lab, IE: pro-time/INR, when drawn, amount of medication receiving and the result.

Abnormal Lab Values:

1. Upon receipt of the hard copy of abnormal labs the charge nurse or designee will review, initial as reviewed, and send a secure conversation or call the physician/medical provider of the results to obtain further instruction/orders. The note must address the lab, IE: pro-time/INR, when drawn, amount of medication receiving and the result. The lab slip will be dated and signed off by the charge nurse or designee that the doctor was notified.

Normal Lab Values:

1. Upon receipt of the hard copy revealing normal lab values, the charge nurse or designee will review, initial as reviewed, send a secure conversation or call the medical provider about the normal results and then place the copy in the ward clerks basket to be scanned into the EMR.

References:

- a. Centers for Medicare & Medicaid Services, U.S., Department of Health and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities. Laboratory, radiology and other diagnostic services* 483.50

Revised 06/16, 11/19

LIGHT DUTY-NURSING STAFF

1. In the event a nursing staff member has a physical limitation as the result of a work related injury, the following will be implemented:
 - a) The RN Manager and/or Director of Nursing will be responsible for determining appropriate work assignment(s)/schedule for a nursing employee with physical work limitation(s).
 - b) Work assignments will be based on medically documented restrictions, staffing needs of the facility, and the employee's regularly scheduled shift.
2. Staffing pattern for certified nursing assistants restricted to light duty shall be based on facility needs in a manner that promotes resident's physical, mental and psychosocial well-being.

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Revised 10/05

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LIGHT DUTY JOB DESCRIPTION

Below is a list of duties that are included in the Light Duty job description for Idaho State Veterans Home. Please review and indicate at the bottom of this form if this employee is able to return to our tight duty position. If there are any items that you feel he/she is unable to perform, simply cross out the item and initial.

1. Making beds
2. Assist with lifting using mechanical devices
3. Helping residents dress/undress, including shoes and socks
4. Taking Vital Signs
5. Cleaning and drying of w/c's.
6. Straightening of closets
7. Clean out basins by sink
8. Passing Ice Water
9. Clean and organize bedside stands
10. Organize and straighten rooms
11. Toenail and fingernail trims (unless resident is diabetic)
12. Shaving residents
13. Dental and hair care
14. Pushing w/c's to and from dining room and resident rooms
15. Dining room duties, i.e.: serving trays, getting drinks, picking up trays, recording meal percentages, washing hands and faces
16. Straighten and organize linen closets
17. Organize and mend clothes in the clothing room
18. Filing various documents in the medical record
19. Auditing of various nursing flow sheets
20. Answering the phones and taking messages
21. Other various clerical duties as assigned by the RNM, DNS or HIS
22. Assist with one on one's with residents, ie. read a book, talk, play pool, play cards
23. Obtain VS and record in chart
24. Meal Times are the residents most important times of the day so Light Duty hours are as follows. 6 a.m. to 9:30 a.m.; 11:30 a.m. to 2:00 p.m.; 5 p.m. to 7 p.m. in an effort to make the dining experience a good experience.

Revised 10/2005

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Light Duty Job Description and Hours to be worked.

- 0600 - 1000 To do Vital Signs and monthly weights and record in resident medical record.
Pass Ice Water
Assist with meals in dining room during entire meal time
- 1130 - 1400 Same as above
- 1700 - 1830 Same as above: Meal time is most important and may not be able to do all vital signs and pass all ice water.

Revised 10/05

BED/CHAIR ALARMS

Purpose:

To ensure wheelchair and bed pressure alarms are maintained in good working order.

Procedure:

1. In consultation with nursing staff the facility's storekeeper shall be responsible for ensuring wheelchair and bed pressure alarms, are available as the needs arise.
2. Each alarm device shall have a regularly scheduled plan to replace battery(ies).
 - a) The Night Shift shall be responsible for replacing alarm batteries.
 - b) The Night Shift shall maintain a list of each resident's device.
3. Each pressure pad is clearly marked with the date put into use and the date of anticipated expiration (in accordance with the manufacturer's guidelines). The storekeeper shall be responsible for the retrieval of expired pads and their replacement.
4. Alarms assigned to residents will always be turned on and operational.
5. After resident transfer staff will observe that the bed or chair alarm is connected, properly placed and turned on.
6. Staff will maintain a line of vision with resident when toileting and showering for residents assigned alarms.
7. Residents with bed or chair alarms will be reassessed for need on a regular basis.

Reviewed 01/15, Revised 05/20

NURSING CLOTHING AND UNIFORM PROCEDURE

Professional Attire in the Workplace

It is important that everyone who works at ISVH-P present a professional appearance to residents and families. The purpose of the dress code is not to inhibit personal freedoms, but rather to acknowledge the unique role that staff have in resident care.

Uniforms are required and are expected to be clean, neat and of appropriate size.

Uniform components for nursing staff are:

- Solid or print scrub tops worn with uniform style slacks that are in good repair.
- Tops and slacks are to be of matching colors or coordinated prints.
- Inappropriate slacks include jeans, sweat pants, leggings, flannel pants, spandex or form fitting pants such as would be appropriate for biking or recreational activities, capris made of cotton or synthetic cloth is acceptable. Capris made of jean material are appropriate only on designated “jeans days”.
- Exposure of body parts such as the abdomen, torso or chest due to low cut shirts or pants is not appropriate. Tank tops and/or sleeveless tops are prohibited unless worn with a lab coat. In the summer months capris may be worn but must be uniform or casual dressy style and worn below the knee.

Shoes:

- Shoes should be comfortable, clean and in good repair.
- Open toe shoes are prohibited for safety reasons.
- Shoes will be low heeled and have non- skid soles.
- Crock style shoes are acceptable but must be worn with socks for infection control purposes.

Grooming:

- Finger nails should be kept short, clean, neatly manicured.
- Hair is to be clean, well groomed, a natural hair color and worn in such a manner that it will not interfere with resident care and will present a professional image.
- Facial hair must be trimmed and kept clean.
- Hats are not allowed.
- Earrings should be worn in a professional manner.
- Piercings, there will be no visible body piercing, including but not limited to tongue piercing, nose piercing, lips and eyebrow rings/bars.
- There will be a limited amount of ring/hand jewelry. Jewelry worn on hands will not have any sharp edges that could cause scratches etc. to residents when giving care.
- Women may wear make-up in moderation.

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Perfume/Cologne:

- Should be worn at a minimum or not at all. Many residents/visitors/staff have allergies or respiratory concerns that are exacerbated by strong fragrances.

Identifying Nametag:

- Nametags are part of the uniform and are to be worn at all times when on shift.

Casual Clothing:

- Casual clothing may be worn each Friday. For the purposes of this procedure, casual clothing is jeans in good repair not worn with any offensive tee-shirts, shirts or sweaters. No shorts or hats shall be worn.

Activity Day Clothing:

- Special attire is occasionally requested by the Activities Committee to help celebrate special events. Such clothing is worn on a voluntary basis and may include shorts for outings.

The Administrator of ISVH-P shall be the final authority on all matters regarding professional grooming and attire.

Revised: 1/15

OVERTIME

Overtime will be paid to staff members if authorized by supervisory personnel.

Hands-on caregivers receive overtime at 1 and 1/2 times the hourly rate. LPN's and RN's receive overtime pay at 1 and 1/2 times the hourly rate.

If in-service time takes the employee over forty hours in a one-week time period, he/she will receive 1 and 1/2 times the hourly rate which may be paid for or compensatory time accrued.

Revised 01/15

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QUALITY ASSURANCE PROGRAM

Purpose:

This facility will have a Quality Assurance Program designed to identify issues in the facility that require quality assessment activities to ensure compliance with state and federal regulations, quality of care, and standards of practice.

Procedure:

Committee Responsibilities

1. QA committee meetings will be held on a quarterly basis, or more frequently depending on facility need.
2. The committee shall consist of the facility Administrator, Director of Nursing Services, the Medical Director, department team leaders, and other interested parties.
3. All committee members will be expected to attend each meeting regardless of their reporting responsibility.
4. The Administrator (or designee) is chairperson.
5. The Chairperson will accept or assign responsibility for taking/transcribing the minutes of the meetings and for maintaining committee minutes, reports, schedules and other pertinent data.

Quality Assessment

6. Quality Assurance items to be monitored will be established by the committee, interested parties, needs of the facility/residents and in accordance with pending and subsequent VA and L&C surveys/findings.
7. Typically the facility will regularly review and trend items such as incident/accidents, resident-to-resident altercations, medication errors, adverse drug reactions, sentinel events and infection control rates.
8. A threshold percent may be established for each of the Quality Assurance items. Percentages less than threshold or more than the national standard shall have a plan of action to address corrective actions/interventions planned.
9. In addition to the above, facility staff or other interested parties may ask the Committee to evaluate other concerns within the facility.

Quality Indicators

10. The RAI -24 QI indicators will be reviewed in the QA Committee.
11. The Director of Nursing Services (or designee) is responsible for obtaining the facility's QI profile, reviewing each of the areas and developing plans of action for each item above the 75 percentile rank, those items which are "flagged" or identified as a sentinel event.

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Plans of Action

1. Plans of action will be developed for each QA monitor that does not meet threshold or is above the national standard.
2. Plans of action will be developed for each QI monitor that is above the 75 percentile rank, those items which are “flagged” or identified as a sentinel event.
3. The plans of action shall include the specific problem, the planned intervention, person(s) responsible for the interventions, evidence of improvement, and the target date of completion. ,
4. Monitor(s) not in compliance shall be reviewed each meeting with action plans revised as appropriate and until resolved.
5. The committee members are responsible for providing input into the development of the plans of action.

Reviewed 03/18

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Physician Recaps - non-electronic signatures:

Procedure:

1. Prior to the end of each month, the physician orders will be printed from the facility's computerized data base by the ward clerk.
2. The ward clerk will forward the physician recaps to the pharmacist for drug regimen review.
3. The pharmacist will complete the review and fill form out with suggested changes and route the recaps back to the RN manager.
4. The RN manager (or designee) will review the recommendations and make suggestions, as appropriate.
5. Deletions to the recaps must be made prior to the physician signing and must be dated and initialed by the person making the changes.
6. Following the review of these items, the forms will be returned to the ward clerk for processing – recaps will be forwarded to the resident's primary physician for signature.
7. Following the review and signature by the physician, the form will be returned to the ward clerk for processing – recaps will then be forwarded to the Director of Nursing for review and signature. The Director of Nursing will return the signed recaps to the RN Manager and then filed into the resident's medical record.

Once the recap has been signed and dated by the physician – no one can alter it.

Revised 06/2016

Electronic Signature Attestation Procedure

Purpose: To ensure and attest that we have safeguards in place to prevent unauthorized access and reconstruction of information

Procedure:

The computers have built-in safe guards to minimize the possibility of fraud. Our EHR is set to time out if there has been no activity in a specific amount of time. The employee will have to log back in with their own individual identifier in order to access the EHR again.

Each employee has an individual identifier specific only unto themselves. All employees are given a unique login at time of employment and are to use this each time they access the EHR. The date and time recorded in the EHR is set from the EHR mainframe and is not able to be falsified, so the date and times on all electronic signatures are accurate and tamper-proof.

An entry is not changed after it is recorded. After an electronic signature has been recorded, there is no option to remove or delete. The original author only has the capability to strike-out in instances of error.

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The computer program controls what sections/areas any individual can access or enter data, based on the individual's personal identifier, assigned security roles and therefore his/her level of professional qualifications. Each employee is only given access to any section in the EHR based on the functions of their job and are not given access to more than minimum necessary to complete their job functions.

Physician Recaps-electronic signature

1. Prior to the end of each month, the physician orders will be printed from the facility's computerized data base by the ward clerk.
2. The ward clerk will forward the physician recaps to the pharmacist for drug regimen review.
3. The pharmacist will complete the review, fill a form out with suggested changes and notify RN Manager (or designee) and physician by Secure Conversation.
4. The RN manager (or designee) or DON will review the recommendations and make suggestions, as appropriate, and will make changes to medical record as ordered by the physician.
5. Deletions or changes to the recaps must be made in the resident's electronic chart and electronically signed by the physician separate from recaps.
6. Following the review the signed forms will be returned the DON to verify signatures. The forms will be forwarded to the ward clerk for processing. Recaps will be electronically signed by primary physician.

06/2016

WANDERING (ELOPEMENT) PROTOCOL

Purpose:

To ensure resident safety, prevent adverse events and receive appropriate care in accordance with the person-centered plan of care addressing their unique factors contributing to wandering or elopement risk.

Prior to or upon admission:

1. The Charge Nurse or Admissions Coordinator (or designee) will conduct an elopement assessment.
2. Elopement assessment will be updated quarterly by MDS Coordinator (or designee).
3. Using the elopement assessment data, a resident who is ambulatory or self-mobile in a wheelchair and has at least one of the following components: a) diagnosis of dementia, Alzheimer's or delusions, b) a history of elopement or c) making statements of leaving/not needing to be here will be considered a high risk for elopement.
4. Once a resident has been identified as high risk for elopement, the Elopement Risk/Exit Seeking Care Plan will be initiated by the Social Worker (or designee) to create with the resident and family a personal care plan of interventions to assist in resident safety while respecting resident.

If a nursing care resident cannot be located the following steps will be immediately initiated:

1. The Charge Nurse will be notified immediately.
2. The Charge Nurse will then retrieve the elopement tool bag from the counter in the chart room and initiate the Elopement Check Sheet.
3. The Charge Nurse (or designee) will overhead page the resident two times, using full name, speaking slowly and distinctly, requesting the resident to come to the nurses' station. (If at any time the resident is located, Charge Nurse must page overhead X2 the name of the resident and "all clear" it: John Doe, all clear)
4. The Charge Nurse is to call/radio all other nursing personnel on that shift describing who is missing. Then:
5. Assure resident is not on an activity, at a doctor appointment or signed out.
6. Send 2 care givers to walk around the perimeter of Veterans home in opposite directions. Cell phones/communication devices are to be utilized by anyone exiting the building to look for the resident. Flash lights kept at the nurses' station are to be utilized after dark
7. Send 1 caregiver from each wing to search their hallway (including all rooms, bathrooms, hall closets and common areas), marking each door with a dry erase marker after thorough check.
 - b. East – include chapel, puzzle room, library, dirty linen, resident rooms, courtyard and staff lounge.
 - c. South – include south dining, shower, dirty linen, locker and resident rooms and nurses' station.

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- d. West include – storage, dirty linen, therapy, activity rooms, resident rooms and bath and tub rooms.
7. Send caregiver to search the family room, dining room, beauty shop, smoke room, canteen, laundry, and bathrooms on the north end of the building.
8. If resident location remains undetermined, Charge Nurse (or designee) will notify Administrator (or designee) (208-241-8638) and DNS (or designee) (208-680-2099) who will initiate the phone tree. If unable to contact either call RNM (or designee) (208-241-1615) or SDC (or designee) (208-643-2740).
9. After perimeter check, expand to North Alvin Ricken and South Alvin Ricken (include adjacent businesses) and west field toward freeway (state vehicles may be used for this search). At this time video surveillance may be reviewed by Administrator or Maintenance Foreman to assess direction resident left ISVH-P grounds.
10. If after 20-30 minutes all efforts have failed, notify family, the police (208-234-6100), and ISU Public Safety (208-282-2515). Calls can/should be placed earlier if indicated by resident medical condition, incimate weather, resident mobility, etc.
11. Searching for the individual will continue until information is received, or resident is located. Report in detail to law enforcement and show a photo of the resident. The search will fall under their direction.
12. Once resident is located, Charge Nurse will immediately contact family.
13. Charge Nurse will then forward a report to the DNS, RNM, and Administrator containing the following data:
 - a. Time elopement occurred (or time first noted when resident was missing).
 - b. Steps initiated and time when completed.
 - c. Activity/Location from where elopement occurred
 - d. A statement from all staff on shift, roommates and other residents/visitors who were present.
 - e. Charge Nurse (or designee) will document any pertinent resident information such as: recent mentation, confused, alert oriented, statements of leaving facility, recent room change.
 - f. Charge Nurse (or designee) will include outside temperature and pertinent weather information as well as residents clothing worn at the time of elopement.
 - g. Hall nurse will do a skin assessment and document any new issues
 - h. Initial plan of prevention indicating where safety breakdown occurred.

Nursing Home Leadership team, Administrator, DNS and RNM will hold quarterly Elopement Drills to assist staff preparedness for Elopement Protocol.

Revised 10/2016, 12/2018, 3/2019

WANDER GUARD MONITOR PROTOCOL

Puopse:

To ensure resident safety, prevent adverse events and receive appropriate care in accordance with the person-centered plan of care addressing their unique factors contributing to wandering or elopement risk.

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1. Prior to wander guard/scandent placement on a resident (in non-emergent circumstances) the Elopement Risk/Exit Seeking Care Plan (done by Social Worker/designee) and the Alarm Assessment (done by Charge Nurse/designee) will be conducted and wander guard will be placed if appropriate.
2. All residents with a wander guard/scandent will have a quarterly Alarm Assessment done by the fall committee to evaluate if continuation would be appropriate for resident safety.
3. Wander Guard System will be tested monthly by the Maintenance Foreman (or designee).
4. Scandent placement in items for elopement risk will be documented by item and resident and reported to the Senior CNAs (or designee) once placed.
5. Senior CNAs will be responsible for maintaining a master list of all Scandent items related to high risk elopement residents in their office.
6. Scandent items related to elopement risk will be tested monthly by the Evening Senior CNA (or designee).

The Wander Guard System has been installed on six (6) doors at the ISVH-P. These doors are:

1. Main Entrance
2. Canteen
3. Dining Room
4. Shipping
5. Puzzle/TV Room
6. Chapel

If a resident has a transistor bracelet on and approaches one of these doors the alarm will sound.

There is an annunciator panel in the facility which is Located at the nurse's station. The panel will signify which door is sounding the alarm. Staff **must** get a visual from a staff member via in person, by radio or phone before silence or reset. The alarm can only be reset at the nurses' station and should only be reset when it is determined who set the alarm off, time it was set off and staff member resetting the alarm. (Document on the clipboard at the nurse's station). This information will be maintained by the CQI Committee to evaluate the effectiveness of the Wander Guard Elopement Protocol.

The Scandent System has been installed on two (2) doors at the ISVH-P. These Doors are:

1. Main Entrance
2. Kitchen Exit

If a resident has a Scandent tag placed in clothing or items for elopement risk purposes and leaves the facility, an automatic text will be sent to the Administrator, DNS, RNM and Charge Nurse cell phone stating "The Scandent system has detected High risk resident at "Main Entrance" on 06:00 PM. Staff **must** get a visual of the resident and maintain visual until resident has returned safely to the facility.

Reviewed 10/16, revised 3/2019

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ELOPEMENT CHECK SHEET (RN Charge DAY SHIFT/EVE SHIFT)				
1	Ensure resident is missing (not with activities, family, outing, appointment)			
2	Page resident name overhead x2 to come to Nurses' Station			
3	Send 2 caregivers around perimeter		Staff sent	Staff sent
4	Send staff to Search East and south rooms (mark checked room with dry erase marker)		Staff sent	Staff sent
5	Send staff search West and North rooms and offices, kitchen etc. (mark checked room with dry erase marker)		Staff sent	Staff sent
6	Charge Nurse, (or disignee) notify Administrator, DNS, RNM or SDC who will initiate phone tree		Administrator 241-8638 DNS 680-2099	RNM 241-1615 SDC 643-2740
7	Expand search with vehicle or on foot		Staff sent	Staff sent
8	Prepare Picture & information ready for Police			
9	Notify Family		Name	
10	Police		Police 234-6100	
11	Notify Public Safety		ISU Safety 282-2515	
12	Work with police as directed			
13	Follow-up with Administrator and DNS and document as directed			
14	Document Temperature and weather			

ELOPEMENT CHECK SHEET (RN Charge NOC Shift)				
		Time	Staff Sent	Staff Sent
1	Ensure resident is missing-not OOB or on pass			
2	Page resident name overhead x2 to come to Nurses' Station			
3	Send 2 caregivers around perimeter		Staff sent	Staff sent
4	Send 1 staff to search all halls		Staff sent	
6	Charge Nurse notify Administrator, DNS, RNM or SDC who will initiate phone tree		Administrator 241-8638 DNS 680-2099	RNM 241-1615 SDC 643-2740
7	Expand search with vehicle or on foot		Staff sent	Staff sent
8	Prepare Picture & information ready for Police			
9	Notify Family		Name	
10	Police		Police 234-6100	
11	Notify Public Safety		ISU Safety 282-2515	
12	Work with police as directed			
13	Follow-up with Administrator and DNS and document as directed			
14	Document Temperature and weather			

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SECURING FACILITY AFTER HOURS

Purpose:

To provide for safety for residents, staff, visitors and contractors at the Idaho State Veterans Home – Pocatello (the home).

Procedure:

1. Evening shift charge nurse (or designee) will secure the main entrance doors nightly between 20:30 and 21:00 each evening. This is done by locking the front sliding door by turning the lock until it latches. The canteen may be used to exit at any time, but re-entry will not be granted through the main entrance.
2. Once the facility is secured and the main entrance doors are locked, they may only be unlocked in an emergency. Staff going outside for any reason other than an emergency must either use the back patio, exit through the canteen (no re-entry because that door remains locked at all times) or leave and re-enter through the loading dock key coded doors.
3. NOC shift staff and others coming on duty after 20:30 are requested to park at the north end of the building near the loading dock. Parking can be done parallel along the north curb or on the front row parking. Do not block the loading dock. This entrance is well-lit and the entry / exit code 2589* (there is a 5 second delay).
4. The NOC shift Charge Nurse (or designee) unlocks the front doors between 05:15 and 05:45 to allow ready access for the day shift staff.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PPGuidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F563 – *Visitation Rights 483.10(f)(iii)(v)*.
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PPGuidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F584 – *Safe Environment 483.10(i)*.

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LOCKDOWN PROCEDURE

Purpose:

The ability to lockdown Idaho State Veterans Home-Pocatello (the home) in the event of a natural or man-made emergent event which threatens the safety of residents, employees, staff and visitors and/or operations is of paramount importance.

Procedure:

1. Once a threat has been identified necessitating a lockdown, the Charge Nurse is to retrieve the **Lockdown Check List** (found either in the charge nurse binder or on Nursing(N:) drive in the Charge Nurse folder).
2. Charge Nurse (or designee) to follow and fill out the **Lockdown Check List**, attached.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities*. (March 2019 Revision) *Emergency Preparedness* 483.73.
- b. *21017-2022 Health Care Preparedness and Response Capabilities*,
<https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/hpp-pmi-guidance-2017.pdf>

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LOCKDOWN CHECKLIST		
	Time of assignment / notification / occurrence	
Charge Nurse initiate lockdown "Note threat which initiated lockdown and source".		Source of threat:
Announce "Facility Lockdown" 3 times on the phone page system, call over the 2 way radios "all staff please assure your car doors are locked".		
Assign 1 staff to lock all facility doors.		Staff assigned:
Assign 1 staff to walk the parameter (with a 2 way radio) assuring all staff and residents are in the facility and all windows are closed.		Staff Assigned:
All residents returned in facility.		Residents brought inside:
All staff in facility, car doors locked.		
Assign 1 staff to monitor the front door and let staff / appropriate people enter as well as place lockdown notice.		Staff Assigned
Assign each LPN to conduct resident and staff census for their hallway using the 2 way radio to confirm census to charge nurse.		East LPN: West LPN: South LPN:
Charge Nurse (or designee) notify Administrator, Building Foreman, DNS and RN Manager of lockdown. Include Threat.		Administrator: Josiah (208)-241-8638 Building Foreman: Cornell (208)-251-0026 DNS: Troy (208)-680-2099 RN Manager: Matt (208)-241-1615
Charge Nurse (or designee) notify Quality Improvement Director IDVS and Deputy Administrator IDVS of lockdown (include threat).		Quality Impromement Dir: Colleen (208)-780-1614 Delputy Admin. IDVS: Tracy (208)-780-1320
Assign Staff to notify all ancillary contractors about the lockdown.		Staff Assigned: PT/OT/ST notified: Housekeeping notified: Contractors notified:
Charge Nurse (or designee) send notice via e-mail with picture or description, if applicable, of saety threat to "Pocatello Employees" and "Pocatello OVA" email groups.		Attach email sent with picture or description to checklist before turning in to DNS:
If threat still present close to shift change, notify incoming staff appropriately.		Staff Assigned:
Charge Nurse (or designee) notify ISU Public Safety and Pocatello Police of lockdown status.		ISU Public Safety (208)-282-2515 Pocatello Police: (208)-234-6142
Assign staff to notify resident's families and guardians of the lockdown status.		Staff Assigned:
Threat discontinuation "note source of discontinuation".		Source / Reason for discontinuation:
Announce "Facility Lockdown discontinued" 3 times on phone page system.		
Assign staff to unlock doors and remove threat notice poster.		Staff assigned:
Charge nurse (or designee) notify Administrator, Building Foreman, DNS, and RN Manager of lockdown discontinuation.		Administrator: Josiah (208)-241-8638 Building Foreman: Cornell (208)-251-0026 DNS: Troy (208)-680-2099 RN Manager: Matt (208)-241-1615
Charge Nurse (or designee) notify Quality Improvement Director IDVS and Deputy Administrator IDVS of lockdown discontinuation.		Quality Impromement Dir: Colleen (208)-780-1614 Delputy Admin. IDVS: Tracy (208)-780-1320
Carge Nurse (or designee) notify ISU Public Safety and Pocatello Police of lockdown status.		ISU Public Safety (208)-282-2515 Pocatello Police: (208)-234-6142
Make sure check list is complete, turn check list over to DNS.		

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VISITING HOURS FOR THE NURSING WING

Normal visiting hours will be from 10 a.m. to 8 p.m. daily. However, family and support system visits will be accommodated at any time and encouraged by all personnel.

Immediate family members (one, 1) will be entitled to one free meal per month to share with residents at this facility. Please let charge nurse and kitchen know at least two hours in advance. If holiday meals are planned, please let appropriate people know at least one week in advance.

Members of the clergy are admitted at any time. Please check with charge nurse if treatments need to be rescheduled or if privacy is needed.

When a resident is critically ill or terminal, family members will be accommodated as requested. The family room may be made available. If possible, a private room will be provided at this time for the privacy of residents and family.

Reviewed 01/15

RESIDENT TRUST PETTY CASH - NURSING STATION

To meet Federal Medicaid rules for access to Resident Petty Cash funds, a separate petty cash fund will be maintained at the Nursing Station 24 hours a day, seven (7) days a week. The Resident Trust Petty Cash Fund —Nursing Station will be maintained at \$50.00. The custodian will be the designated Director of Nursing Services.

Residents will have access to their Trust Accounts during regular business hours at the front desk of the business office.

Residents will have access after regular business hours and weekends at the Nursing Station.

The petty cash funds will be secured in the locked drawer at the nurse's station. Should a resident need money out of it, the Charge Nurse may break the seal and accommodate the resident. When the seal is broken the money will be counted by the Charge Nurses at shift change until the money can be witnessed by two people and resealed. The assigned office staff tracking the money will be notified as a change of seal and will verify and enter the numbers into maintained log. If a resident wishes to withdraw money from resident trust petty cash after hours the charge nurse will document on a withdrawal slip showing the date, name of resident, withdrawal amount and resident/staff signatures.

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The director of nursing will turn in any withdrawal or deposits the next business day for posting to the residents' accounts.

A rotary check will be used to replenish the Resident Petty Cash-Nursing Station Account

NURSING DAILY STAFF POSTING

There is a requirement that nursing post daily staffing. The RN Charge for each shift is responsible for completing that shifts section. The night shift RN will place a new sheet each AM and will record the oncoming shift Census and employee numbers. Each shift the LN assigned to the West wing will record the number of RN's, LPN's and CNA's. The LN will record the total hours worked for each discipline. Example 2 RN's would equal 16 hours worked etc.

1. The nurse staffing information will be posted daily and will contain the following information:
 - a. Facility Name
 - b. The current date
 - c. Facility's current resident census
 - d. The total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift:
 - i. Registered Nurses (do not count DNS, RNM, IP/SDC, or MDS Coordinator)
 - ii. Licensed Practical Nurses / Licensed Vocation Nurses
 - iii. Certified Nurse Aids including Restorative CAN (do not count Transport Aid)
2. The facility will post the nurse staffing data at the beginning of each shift.
3. The information posted will be:
 - a. Presented in a clear and readable format
 - b. In a prominent place readily accessible to residents and visitors
4. A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current.
 - a. The information shall reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated to reflect such.
 - b. Staffing shall include all nursing staff who are paid by the facility (including contract staff). Any staff not paid for by the facility, such as hospice staff or individuals hired by families, shall not be included.
5. Nursing schedules and posting information will be maintained for review for at least 18 months or according to state law, whichever is greater.
6. The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

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References:

- a. Centers for Medicare & Medicaid Services, U.S., Department of Health and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities. Nurse Staffing Information 483.35(g)(1)(2)(3), F732*

03/2019, Revised 11/2019

DAILY STAFF POSTING

DATE _____

IDAHO STATE VETREANS HOME-POCATELLO
Nursing Hours On Duty

Licensed Staff on Duty _____

Total Hours of Licensed Staff _____

C.N.A. Staff on Duty
(Includes R.A.) _____

Total Hours of C.N.A. Staff _____

Total Census for Residents _____

DINING ROOM PROCEDURE

POLICY STATEMENT: The Idaho State Veterans staff will utilize aprons to increase visual/homelike environment for residents while serving or assisting with meals.

Apron Procedure:

1. Aprons will be provided in the dining room, located on table by dining room door, to be used by all staff who assist with taking meal orders, assist with feeding residents and pass meal trays and drinks.
2. Should staff need to leave the dining room to deliver a tray to Canteen (considered an extension of the dining room) the apron can remain only if the staff return directly to the dining room.
3. Should staff leave the dining room to give personal cares to a resident the apron should be placed in the receptacle. Upon returning to the dining room, after completing hand washing per protocol, a new apron will be placed.
4. No aprons shall be worn in any other part of the facility.

CNA Dining Room Procedures:

1. One CNA will be assigned to stay on the floor to answer lights etc. while all other CNAs report to the dining room at 0715, 1215, and 1715. A licensed nurse(s) (LN) is to report to the dining room no later than 0730, 1230 and 1730 to assist with dependent residents. The LN's on the floor will assist staff with answering lights etc. The charge nurse for each shift is responsible for making the staff assignments for the dining room at the start of each shift.

Meals: Independent residents may receive drinks earlier than served meal. All residents at one table will be served at the same time. Dependent residents will be assisted to the dining room no earlier than 0715, 1215, and 1715.

A napkin is to be offered to each resident. If a resident prefers a shirt protector staff will assist resident with donning the shirt protector, as needed.

2. Staff will sanitize hands and put on an apron prior to passing food trays and after serving approximately every 5 trays or as needed. During set up of trays, cutting meat, pouring coffee or other liquid, applying salt, pepper, etc. **NO FOOD/DRINK IS TO BE TOUCHED BY STAFF.**
3. Prior to serving food/drinks, staff will encourage residents to utilize sanitizing wipes provided at the dining room entrance and/or each table to wipe hands/face prior to meal/fluid consumption.
4. After helping assisted residents with their meal offer warm washcloth to wash face, hands.
5. The Charge nurse is responsible to assign a nursing staff member to circulate the dining room during each meal to encourage all residents to drink their fluids, even if they are not eating well. Staff is to take the time to help residents with their liquids. Any resident(s)

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that eat less than 50% of their meal will be offered an alternate. Percentage (%) of alternate eaten MUST be charted in the meal monitor or if offered and refused R for refused will be charted. The charge nurse is responsible for assigning a nursing staff member to chart meals in the meal monitor.

6. All spills must be cleaned up immediately by whoever sees them first. They are very dangerous to both residents and staff. 01/15, rev: 07/18

RESIDENT PERSONAL FURNITURE / REFRIGERATOR PROCEDURES

Purpose:

To assure that all outside furniture (chairs and recliners) meets the fire code as well as infection control policy.

Procedure:

1. The furniture (chairs and recliners) must be fire retardant and have washable surface. The furniture (chairs and recliners) will be taken to the Maintenance shop for inspection prior to being brought into the home. Maintenance will inspect for fire and safety concerns and infection control issues.
2. Maintenance will approve the furniture (chairs and recliners) and other equipment prior to being put into use by resident.
3. Should the furniture and/or equipment be delivered on weekend or after hours, it will be held until time that Maintenance can approve it.

RESIDENT PERSONAL REFRIGERATOR PROCEDURES

Purpose:

To ensure safe and sanitary conditions in personal Resident refrigerators while providing a homelike environment.

A. Use of refrigerators:

Refrigerators will not automatically be acceptable in Resident rooms. If a Resident would like a refrigerator, they are to make the request to the Social Worker.

Conditions that need to be met to have a personal refrigerator in a Resident room are as follows:

- The room must be large enough to accommodate the refrigerator and allow adequate space to provide cares and allow for housekeeping (no full-sized refrigerators will be allowed – "mini-fridges" only).
- The room must have an outlet that the refrigerator can plug directly into. No extension cords of any kind are allowed for any equipment with a motor.

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- Placement of the refrigerator must be safe. Refrigerators cannot be placed on top of other furniture unless maintenance has deemed it safe and appropriate.
- Maintenance must inspect the refrigerator for safety to assure only refrigerators in good condition and UL Compliant are allowed.
- The Resident must be capable of obtaining items from the refrigerator independently, otherwise a refrigerator is accessible at the Nurses station.
- The Resident or Responsible Party must be willing and able to maintain the sanitation and cleaning of the refrigerator independently. Refrigerators are to be cleaned a minimum of monthly and as needed for spills. Refrigerators must be kept free of frost buildup.
- Items placed in the refrigerators must be safe for consumption, dated, and discarded when spoiled or outdated. (typically, 3 days).
- Resident owned refrigerators will be checked weekly by kitchen staff to insure items are not outdated and internal temperature is within the safe range (34 to 40 degrees).
- Temperature of the refrigerator must be checked and logged daily. The Resident is responsible for obtaining an easily read thermometer. Temperature must be maintained between 34 and 40 degrees. Refrigerators that malfunction or are in need of maintenance will be removed from the facility.
- If any of the above conditions are not met anytime during the Residents stay the refrigerator will not be allowed.

B. Temperature Monitoring:

- Refrigerators will be monitored daily by nursing for appropriate temperatures.
- The daily temperature will be documented in the resident's TAR in PCC.
- Temperatures above 40 degrees must be reported to Social Services and at that time it will be determined if food is safe to be consumed or must be discarded. Resident and/or Responsible Party will be notified of the malfunctioning refrigerator and they will be responsible for replacing/repairing/disposal is necessary.

C. Refrigerator Monitoring:

- Refrigerators will be checked periodically to ensure food is not spoiled or outdated.
- Refrigerators will be checked periodically to ensure they are clean, free of spills and frost-free.

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I have read the "Resident Personal Refrigerator Procedures" and agree to the terms and conditions contained therein.

Resident / Responsible Party Printed Name

Signature

Date

8/18

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SMOKING AND BREAK REGULATIONS

It is the intent of the Idaho Division of Veterans Services to protect the public health, comfort, environment and the rights of nonsmokers to breathe clean air. Therefore, there will be no smoking permitted in any department buildings. Individual offices shall be included in this policy directive. Time spent smoking away from the workstation is considered a rest break. All rest breaks are discretionary and are governed by the IDVS-L policy. This policy allows a maximum of 15 minutes during the first and the last four hours of any work shift. Employees are expected to be at least 20 feet from any entrance/exit door when smoking. There is an area of the Idaho State Veterans Home designated as resident smoking area only.

All employees of the Idaho State Veterans Home - Pocatello are responsible for acting in accordance.

Revised 01/15

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PERSONAL GIFTS OR GRATUITIES

It is against policy for employees to solicit or accept money from residents of any level of care at the Idaho State Veterans Home to pay for services rendered or errands performed.

Within limits personnel may accept small gifts for special occasions as the falls under the purview of resident dignity.

Before accepting any gifts from a resident you are to let your supervisor know and get approval.

MOTORIZED MOBILITY DEVICE PROTOCOL

Purpose:

To provide those residents the ability to ambulate and/or propel self independently with the safe use of a motorized mobility device while residing at ISVH-P.

Protocol:

ISVH-P subscribes to providing the highest quality of care to all its residents.

ISVH-P will support the use of a motorized mobility devices for those residents who meet the safety standards set forth by ISVH-P and its interdisciplinary team.

Motorized Mobility Device Standards:

1. Initial review by Motorized Mobility Device Committee.
2. Pre-screening done by restorative (RA) team.
3. Evaluation by RA team using the MOTORIZED MOBILITY DEVICE CHECKLIST.
4. Motorized mobility device agreement reviewed with and signed by the resident.
5. Individualized trial will be established with the resident and added to residents personalized care plan, if applicable.
6. RA Team to present the results of residents ongoing evaluation to the motorized mobility device committee for review and final approval/disapproval.
7. Upon final approval the motorized mobility device will be added to residents personalized care plan.
8. The resident is responsible for obtaining (purchasing) and maintaining the motorized mobility device in good working order.

Reviews will be done by the committee with any resident who is using a motorized mobility device as necessary.

Manual wheelchairs may be used on transports and out of the building activities at the discretion of accompanying staff.

The following criteria will be used to determine when the use of a motorized mobility device must be suspended. Any staff at any time after observing inappropriate/unsafe behavior may

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request temporary placement in a manual wheelchair, from the charge nurse. When acute removal is initiated, the RA team will re-evaluate after a prolonged absence from the motorized mobility device.

1. Injury to self or other.
2. Damage to property.
3. Leaving the facility without staff notification.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F656 – Develop/Implement Comprehensive care plan. 42 C.F.R. 483.24 (b)(2), F675 – Quality of Life 483.24, and F688 – Mobility 483.25 (c)(3).

Revised 05/2011, 2/2020

MOTORIZED MOBILITY DEVICE SAFETY CONTRACT

I, _____ understand that the use of a motorized mobility device at the Idaho State Veterans Home is a privilege, not a right, and may be suspended or terminated at any time that a problem arises.

In order to use a motorized mobility device in this facility, I agree to adhere to the following rules:

1. I will not injure myself or others.
2. I will not damage property belonging to myself, other people, or the facility.
3. I will not leave Idaho State Veterans Home property without staff notification.
4. I will keep the speed of my motorized mobility device at an appropriate/ safe level as determined by the motorized mobility device committee.
5. I may participate in the RA program to maintain strength and functionality.

If it is determined that problems with these requirements have occurred, the committee will review the issues and determine if use of the motorized mobility device must be suspended or terminated.

I also agree and understand that should the time come that I cannot safely operate my motorized mobility device, I will no longer use it in this facility.

Resident

Date

Copy to be provided to Resident/Responsible party

Revised 2/2020

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MOTORIZED MOBILITY DEVICE TRAINING CHECKLIST
DEMONSTRATED TASK

		NOT MET	MET	SIGNATURE
PRE	Assessed to be appropriate by nursing (orientation status, aimlessly wanders, lethargy/sedation, visual impairment or deficit, etc.)			
PRE	Review by Pharmacy for appropriateness (recommend to operate motorized device safely with training)			
PRE	Review by MD for appropriateness (recommend to operate motorized device safely with training)			
1	Prior experience maneuvering a motorized mobility device? If yes, how long?			
2	Demonstrates awareness of control unit on chair.			
3	Able to tolerate movement without falling over or out of chair.			
4	Able to release control unit to stop when given a command.			
5	Willing and able to take direction from staff.			
6	Tolerates hand-over-hand assistance from others			
7	Demonstrates the ability to follow requests to go forward, left, right or stop.			
8	Demonstrates the ability to drive motorized mobility device r in an uncrowded hallway.			
9	Able to use horn appropriately (when applicable) to warn others of presence.			
10	Demonstrates the ability to drive motorized mobility device with supervision.			
11	Demonstrates the ability to maneuver around people and objects.			
12	Demonstrates the ability to drive motorized mobility device in and out of three cones.			
13	Able to maneuver motorized mobility device in tight space (in room, near bed, bathroom, etc.).			
14	Demonstrates the awareness of other people in their pathway and stops chair to prevent hitting others.			
15	Demonstrates the ability to drive through doorways safely and without causing harm to self.			
16	Demonstrates the ability to drive up and down ramps in the home and for transportation purposes.			
17	Recognized changes in surfaces and stops if concerned.			
18	Able to maneuver motorized mobility device outdoors with supervision (checks in with staff before going out).			
19	Begins to learn the concept of backing up with cuing that the area is free of obstacles.			
20	Demonstrates the awareness of space behind and demonstrates appropriate precautions when backing up.			
21	Demonstrates the ability to turn on and off the motorized mobility device with indirect supervision.			
22	Demonstrates the ability to maneuver through crowded hallways with indirect supervision.			
23	Demonstrates the ability to freely maneuver motorized mobility device with indirect supervision.			
24	Demonstrates independence with motorized mobility device.			
25	Demonstrates safety by keeping speed at a minimum while indoors.			

* Areas that are "NOT MET" will require further observation and training

RESIDENT NAME _____

DATE _____

THERAPIST/RA OBSERVER _____

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ACRONYMS USED AT THE IDAHO STATE VETERANS HOME-Pocatello

ac	Before meals
ADA	American Diabetic Association
ADL	Activities of Daily Living
AKA	Above the Knee Amputation
ASA	Aspirin
am	Morning
B&B	Bowel and Bladder
BG	Blood Glucose (finger stick unless otherwise indicated)
BKA	Below the Knee Amputation
Bid	Twice a day
BM	Bowel Movement
B/P	Blood Pressure
BRP	Bathroom privileges
BS	Blood sugar, Bowel Sounds, Breath sounds, depending on the context and use in the sentence.
C	with
CBC	Complete Blood Count
CHF	Congestive Heart Failure
CNA	Certified Nursing Assistant
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardio Pulmonary Resuscitation
CRF	Chronic Renal failure
CVA	Cerebral Vascular Accident
d/c	Discontinue or discharge depending on the context and use in the sentence.
DM	Diabetes Mellitus
DN I	Do Not intubate
DNR	Do Not Resuscitate
DNS	Director of Nursing Services
DON	Director of Nursing Services
DOB	Date of Birth
DVS	Division of Veterans Services
et al	And all
ECG	Electrocardiogram
EKG	Electrocardiogram
EEG	Electroencephalogram
ETOH	Alcohol
ESR	Sed Rate
FSBS	Fasting Stick Blood Sugar
F/U	Follow up

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GI Gastrointestinal
gtts Drops

Hr Hour
HS Hour of Sleep
HT Height

JMA Joint Mobility Assessment

IDDM Insulin Dependent Diabetes Mellitus

IDT Interdisciplinary Team

I&O Intake and Output

IM Intramuscularly

IV Intravenously

LPN Licensed Practical Nurse

MD Medical Doctor or Medical Director depending on the context

MDS Minimum Data Set

MI Myocardial infarction

MVI Multivitamin

MVA Motor Vehicle Accident

N/G Naso/Gastric

NKDA No Known Drug Allergies

NN Nurses Notes

NO New Order

NP Nurse Practitioner

NPO Nothing by Mouth

OD Right Eye

OS Left Eye

OU Both Eyes

OOB Out of Bed

OOF Out of Facility

OT Occupational Therapy or Occupational Therapist, depending on context

P Pulse

p After

PA Physician Assistant

pc After Meals

PERL Pupils Equal & Reactive to Light

PERLA Pupils Equal & Reactive to Light and Accommodation

PM Afternoon & Before Midnight

PO By Mouth

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PPD	Purified Protein Derivative
PR	Per Rectum
PRN	As Needed
PT	Physical Therapy or Physical Therapist, depending on the context
q	Every, may also be capital Q
qd	Every day, may also be capital QD
QID	Four times a Day
QOD	Every Other Day
QS	Every Shift
qs	Quantity Sufficient
R	Respirations
RA	Restorative Aide
RN	Registered Nurse (Licensed Professional Nurse)
RNM	Registered Nurse Manager
ROM	Range of Motion
Rx	Prescription
s	Without
S&S	Signs and/or Symptoms
SL	Sub Lingual
SO	Standing Order
SQ	Subcutaneous
ST	Speech Therapy or Speech Therapist depending on Context
T	Temperature
TB	Tuberculosis
TIA	Transient Ischemic Accident
TO	Telephone Order
UA	Urinalysis
UA/C&S	Urinalysis with Culture & Sensitivity
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VA	Veteran's Administration
WNL	Within Normal Limits
Wt	Weight

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III ADMISSION/DISCHARGE/TRANSFER

ADMISSIONS PROCEDURE

Residents are admitted to Idaho State Veterans Home nursing care at the request of a physician certifying the applicant as requiring skilled nursing care.

An application is then filed out and returned to the Social Worker or Admissions Coordinator.

The admittance

is prioritized according to level of care and room availability. The applicant is reviewed by the Admissions Committee and placement is determined. At the time of admission, every effort will be made to choose a suitable roommate if indicated.

Once on the unit, the admissions process is continued by the unit Licensed Nurse or Charge Nurse, the assigned caregiver, LSW and the ward clerk.

The resident's primary physician will write orders for medications, laboratory, x-ray, therapies and other pertinent programs at or prior to the time of admission.

A photograph will be taken to place in the medication administration record.

PROTOCOL FOR ADMISSION LAB & X-RAY PROCEDURE

The following tests will be performed on all residents being admitted to the Idaho State Veterans Home nursing unit:

Admission Labs are: CBC, TSH, PSA (if applicable), any other labs that the physician may order when admitted unless otherwise indicated by facility protocol.

PPD followed by 2d PPD in 7-14 days (unless resident has history of a positive PPD skin test, then refer to Nursing Procedure - Tuberculosis control plan).

Pneumovax (if applicable)

Influenza Vaccine (as available/appropriate time of year)

Revised 01/15

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NEW ADMISSION DOCUMENTATION GUIDELINES

1. Date, time and room number of admission.
2. How did the resident arrive, from where were they admitted, who accompanied them upon admission. If they were admitted from the hospital then it is important to note their days of stay at the hospital or days of stay at another facility or level of care.
3. Reason for admission and other pertinent diagnoses, especially the reason why they will be skilled for services. **VERY IMPORTANT!**
4. Obtain VS and document.
5. Additional areas of key documentation:
 - a. **Communication:** How do they communicate, is their speech clear, understandable, do they use any assistive devices, can they communicate their needs.
 - b. **Mood Behavior:** s/s of depression, tearfulness, change in affect, any medication changes.
 - c. **Vision:** Note any Limitations and use of assistive devices.
 - d. **Hearing:** Note any limitations and use of assistive devices.
 - e. **Oral Status:** Teeth/dentures, any chewing or swallowing issues, is the diet altered in texture, any c/o oral pain.
 - f. **Respiratory Status:** Document lung sounds, document if there is any SOB (with and without exertion), cough, sputum production.
 - g. **Cardiac Status:** Heart rate, is it regular/irregular, any do chest pain, pedal pulses.
 - h. **GI Status:** Document abdominal sounds, any e/o abdominal pain, tenderness with palpation/exam, any e/o 01 distress (heartburn, N/V, abdominal distention, constipation diarrhea).
 - i. **Nutrition:** Document weight, appetite, is weight loss/gain an issue and if so, what is their UBW, how do they feed themselves, do they need any assistive devices to eat, are they receiving any supplements/tube feedings. If receiving tube feedings, then need to address tube placement, ostomy site condition, toleration of tube feedings/water flush.
 - j. **Functional Ability:** Document amount of assist required for bed mobility, eating, toileting, dressing, transfer, hygiene, ambulation., WC mobility. Be sure to document use of any assistive devices, any physical limitations (contractures, hemiparesis).
 - k. **Fall Risk:** Is the resident at risk for falls, have they had any recent falls? Document what interventions are being put into place (alarms, nonskid rug, etc.), have you oriented the resident to their room, call light, facility routine?
 - l. **Pain Management:** Any e/o pain during the assessment? If so where, quality, duration, what helps, did you do anything to relieve the pain, if so document the intervention.
 - m. **Skin Condition:** Describe the condition of the skin, describe any areas of concern (bruises, abrasions, rash, ulcer) with description of wound, drainage, odor, treatment, interventions in place to prevent skin breakdown (mattress, cushion in WC, posey boots, gen gloves, lotion, etc.) Especially important to document any treatments done during the admission assessment. Edema, where, how much.
 - n. **Notification of MD:** Regarding resident's arrival and verification of orders.

TRANSFER AND DISCHARGE (INCLUDING AMA) POLICY

Policy:

It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered.

Definitions:

“Transfer” refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.

“Discharge” refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

“Transfer and discharge” includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not.

“Resident-initiated transfer or discharge” means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

“Facility-initiated transfer or discharge” is a transfer or discharge which the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.

“Anticipated transfer or discharge” is a transfer or discharge that is planned and not due to the resident’s death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation).

Policy Explanation and Compliance Guidelines:

1. The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility’s ability to meet the resident’s needs.
2. The facility permits each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered.
3. The facility may initiate transfers or discharges in the following limited circumstances:
 - a. The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility.
 - b. The resident’s health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.
 - c. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident.
 - d. The health of the individuals in the facility would otherwise be endangered.

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- e. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility.
 - f. The facility ceases to operate.
4. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.
5. When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.
6. **Non-Emergency Transfers or Discharges** – initiated by the facility, return not anticipated.
- a. Document the reasons for the transfer or discharge in the resident’s medical record, and in the case of necessity for the resident’s welfare and the resident’s needs cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs. Document any danger to the health or safety of the resident or other individuals that failure to transfer or discharge would pose.
 - b. At least 30 days before the resident is transferred or discharged, the Social Services Director will notify the resident and the resident’s representative in writing in a language and manner they understand. (This time frame does not apply if the resident has not resided in the facility for 30 days.)
 - c. Contents of the notice must include:
 - i. The reason for transfer or discharge;
 - ii. The effective date of transfer or discharge;
 - iii. The location to which the resident is transferred or discharged;
 - iv. A statement of the resident’s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; and
 - v. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.
 - vi. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities must be included in the notice.
 - vii. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder must be included in the notice.
 - d. A copy of the notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman.
 - e. If the information in the notice changes prior to effecting the transfer or discharge, the Social Services Director must update the recipients of the notice as soon as practicable once the updated information becomes available.
 - f. In the case of facility closure, the Administrator must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

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- g. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team.
 - h. Assist with transportation arrangements to the new facility and any other arrangements, as needed.
 - i. Assist with any appeals and Ombudsman consultations, as desired by the resident.
 - j. The physician shall document medical reasons for transfer or discharge in the medical record, when the reason for transfer or discharge is for any reason other than nonpayment of the stay or the facility ceasing to operate. A copy of the physician's order for discharge should be attached to the discharge notice.
 - k. For a community discharge, a discharge summary and plan of care should be prepared for the resident. Document in the medical record that written discharge instructions were given to the resident and if applicable, the resident's representative.
 - l. For a transfer to another provider, the following information must be provided to the receiving provider:
 - i. Contact information of the practitioner responsible for the care of the resident.
 - ii. Resident representative information including contact information.
 - iii. Advance Directive information.
 - iv. All special instructions or precautions for ongoing care, as appropriate.
 - v. Comprehensive care plan goals.
 - vi. Other necessary information, including a copy of the resident's discharge summary, as applicable, to ensure a safe and effective transition of care.
7. **Emergency Transfers/Discharges** – initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).
- a. Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis.
 - b. Notify resident and/or resident representative.
 - c. Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements.
 - d. Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents:
 - i. Resident status, including baseline and current mental, behavioral and functional status and recent vital signs;
 - ii. Current diagnosis, allergies and reasons for transfer/discharge;
 - iii. Contact information of the practitioner responsible for the care of the resident;
 - iv. Resident representative information including contact information;
 - v. Current medications (including when last received), treatments, most recent relevant lab and/or radiological findings and recent immunizations;
 - vi. Special instructions or precautions for ongoing care to include precautions such as isolation or contact;
 - vii. Special risks such as risk for falls, elopement, bleeding or pressure injury and/or aspiration precautions;
 - viii. Comprehensive care plan goals, and
 - ix. Any other documentation, as applicable, to ensure a safe and effective transition of care.
 - e. A copy of any Advance Directive, Durable Power of Attorney, DNR or Withholding or Withdrawing of Life-Sustaining Treatment forms should be sent with the resident.

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- f. The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record.
- g. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand.
- h. Document assessment findings and other relevant information regarding the transfer in the medical record.
- i. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.
- j. Provide transfer notice as soon as practicable to resident and representative.
- k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list.
- l. In case of discharge, notice requirements and procedures for facility-initiated discharges shall be followed.

8. Discharge Against Medical Advice (AMA) -

- a. The resident and family/legal representative are informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. The physician should be notified and encouraged to speak with the resident.
- b. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present.
- c. Resident will then be given the ISVH-P release from responsibility for discharge form.
- d. Residents signed release form will then be scanned in the residents' EMR.
- e. If resident refuses signature documentation of the refusal will be documented in the EMR.
- f. Notify Adult Protection Services, or other entity. Document accordingly.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F660 – Discharge Planning. 42 C.F.R. 483.21(c)(1).
- b. Idaho Statutes, Idaho State Legislature: *Title 39, Health and Safety Chapter 3 Alcoholism and Intoxication Treatment ACT, 29-309(3). Acceptance for Treatment-Rules*.

9. Anticipated Transfers or Discharges – initiated by the resident.

- a. Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care.
- b. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following:
 - i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.
 - ii. A final summary of the resident's status.
 - iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).

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- iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment.
- c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team.
- d. Assist with transportation arrangements to the new facility and any other arrangements as needed.
- e. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge.
- f. Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative.

References:

1. Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision). F622, Transfer and Discharge Requirements.
 2. Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (November 2017 Revision). F623, Notice Requirements before Transfer/Discharge.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision). F661, Discharge Summary

9/2019

RESIDENT PROPERTY DISBURSEMENT POLICY

In the event of a resident's death, the following policy will be followed in regards to any of the resident's property in the possession of the Idaho State Veterans home.

1. The Patient Inventory Form will be available in the patient's medical record. The personal property will be packed by family (as available) utilizing the form as it is boxed up. Items in nursing lock-up should also be included in this list and put in a manila envelope and enclosed in the box and verified by family. Any cash in lock-up should be sent to the business office to be deposited into the resident's account. The property should be listed as accurately and descriptive as possible. The form should be signed by the employee/s and the family doing the inventory.. If family is not available, two licensed persons will box the belonging together utilizing the inventory form. Every effort is made to complete the form accurately. The completed form will then be given to the Health Information Manager to be placed in the resident's file.
2. In the event of death on the weekend or after business hours, unless family is present, nothing will be done with belonging until day staff available. . Any money left in the resident's account will be handled by the business office according to the Idaho State Veterans Home's procedures.

Revised 02/15

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SPECIFICATIONS OF CARE LEVEL

LEVEL IV

Residents requiring total care in all aspects of ADL (Feeding, bathing, bowel and bladder care, oral hygiene, etc.). Also may require turning every 2 hours, positioning, ROM. May have treatments such as enteral feedings, O₂ therapy, respiratory therapy, ostomy or decubitus care.

LEVEL III

Residents requiring assistance with most ADL functions. May be able to assist with feeding and some aspects of personal care. Require assistance in and out of bed to wheelchair and/or transfer assistance. Treatments may consist of O₂ therapy, SVN/pulmo-aide treatments, behavior reorientation, constructive ambulating techniques, bowel and bladder training, profound-dementia programs.

LEVEL II

Ambulatory, mildly demented resident requiring direction, re-orientation and cueing. Many will require supplemental nutrition and dietary monitoring. Cognition may be impaired, but still present.

LEVEL I

Ambulatory residents who require supervision for performance of ADL's and minimal assist

Revised 10/2005

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CENSUS PROCEDURE

Each nurse on each of the nursing units is responsible for filling out the census report during their shift. If a resident was discharged or hospitalized the LN assigned to the unit will indicate this on the Census report.

The RNC on night shift will review the Census Report, correct any items needing corrected, and sign off as being correct. The RNC will then turn the Report into the HIS.

1. Admissions Portion

All new admissions will be Listed by name (proceeding 24-how period), time they arrived, where they were admitted from, and what room they were put in.

2. Discharges

All residents discharged will be listed by name, time they discharged, and where discharged to. If a resident expires, indicate the time they died, not the time to body was picked up.

3. Authorized Leaves and Passes

All residents on leave or pass will be listed by name, date and time pass began, date and time returned (if pertinent), and where they are going.

4. Resident at Acute Care Facility

All residents receiving acute care treatment will be listed by name. Time the resident left ISVH-Pocatello and where the resident went.

The form also contains a synopsis of residents admitted and discharged, total number of patients in facility, and the signature of the Night Shift RN.

Revised 06/2006

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24-HOUR REPORT

The purpose of the report is to ensure adequate communication between shifts, ensure timely and appropriate nursing interventions and to keep nursing staff informed of unusual events that have occurred during the shift.

1. A new report will be initiated daily by the NOC shift nurse – one for each oncoming nurse (each wing).
2. The report is divided into two sections, the 24-HOUR REPORT and RESIDENT INFORMATION.
 - a. The top portion of the report (24-Hour Report) will include information that occurs DURING THE SHIFT such as resident accidents/incidents, acute changes in resident condition, residents who were transferred to the hospital/ER, etc.
 - b. The bottom portion of the report (Resident Information) will be completed by the nurse who completed the 24-hour report section directly above e.g. (NOC) shift nurse completes the section (24-hour portion) and then completes the information in the bottom portion for the oncoming day shift nurse.
 - i. The resident information section shall include: Residents who need insulin, wound dressing changes, blood glucose checks, tube feedings, and any other special needs during that shift e.g. transport to doctor appointments, medications set up for out of facility visits, special dressing needs for events, etc. Some of the information in this section will be pre-printed with updates by the nurse as situations change.
3. Once the report has been completed by all shifts and the information passed along through change of shift then the report shall be placed in the RN Manager's in-box.

Revised 10/05, 03/13

DATE: _____		CHANGE OF SHIFT REPORT		WING: _____	
24 HOUR REPORT					
NOC SHIFT		DAY SHIFT		EVE SHIFT	
Incidents/Acute Changes/Transfers		Incidents/Acute Changes/Transfers		Incidents/Acute Changes/Transfers	
RESIDENT INFORMATION					
DAY SHIFT		EVE SHIFT		NOC SHIFT	
BLOOD SUGARS NEEDED: INSULINS NEEDED: WOUND DRESSINGS TUBE FEEDINGS SPECIAL INSTRUCTIONS:(eg. Res going OFF needs to take meds)		BLOOD SUGARS NEEDED: INSULINS NEEDED: WOUND DRESSINGS TUBE FEEDINGS SPECIAL INSTRUCTIONS:(eg. Res going OFF needs to take meds)		BLOOD SUGARS NEEDED: INSULINS NEEDED: WOUND DRESSINGS TUBE FEEDINGS SPECIAL INSTRUCTIONS:(eg. Res going OFF needs to take meds)	

IN-SERVICE EDUCATION

This facility adheres to the notion that learning is integral and lifelong. Further, a strong in-service program of developing ever-increasing abilities and skills supports the intention of excellence in care.

Each nursing department employee will be required to attend 24 hours of in-service training per calendar year (or two hours per month). This in service requirement may be met by one of the following:

1. In-house training provided by the Staff Development Coordinator (SDC, RNM), team leader, or other personnel.
2. Outside seminars relating to health care.
3. Applicable education courses.

There will be a minimum of two hours of in-service per month arranged per month. Some months there will be more so employees may choose which ones are convenient and interesting to them.

1. The in-service will be scheduled at a time convenient to two shifts when possible. Fire Safety in-services will be scheduled quarterly.
2. Staff Development Coordinator (SDC) will post, in advance, monthly schedules stating the time, topic and date of the in-service opportunities and mandatory in-services scheduled.
3. Off-duty employees will be encouraged to attend in-services, although attendance is not mandatory, unless specified.
4. Attendance is required, however, if the notice is marked "MANDATORY." Any employee not able to attend a "MANDATORY" in service must provide a written explanation to the RN Manager or DNS. For the majority of the staff, if an employee works over 40 hours in a one (1) week period, he/she will receive 1 and 1/2 times the hourly rate, which may be paid for or compensatory time worked. (Please be advised that participation in "MANDATORY IN-SERVICES" will be monitored and reflected in performance evaluations).
5. The in service schedule may include:
 - a) Fire safety
 - b) Resident Rights
 - c) Infection Control
 - d) CPR/Heimlich Maneuver
 - e) Death and dying
 - f) Communication skills
 - g) Thicken liquids / types of diets
 - h) Body Mechanics
 - i) Hand in Hand
 - j) Skills signoff
 - k) Policy review/changes
 - l) Dementia
 - m) Hand Hygiene

6. Staff will be paid for all on site trainings offered (both mandatory and voluntary) and Medline trainings that have been specified as "MANDATORY" by Staff Development Coordinator. Time spent doing Medline Trainings that have not been stated as "Mandatory".

IN-SERVICE HOURS

1. After each in-service, the presenter is responsible for getting the sign-up sheet to the SDC or designee to log the date, topic, and number of hours on the individual in-service record form as well as a post test or repeat demonstration assessing personal understanding presented information
2. At the end of each month, the SDC or designee will total the number of in-service hours each employee has earned. The SDC or designee will give each manager a print out of total hours for each employee. The manager will post these in each department for employees to review.
3. The RN Mangers will be responsible for ensuring that all nursing employees have accumulated their mandatory 24 hours of in-services for the year.
4. If an employee is not meeting the requirement of 2 hours of in-service monthly the RNM will discuss with the employee a plan on how the employee will succeed in meeting the requirement and the RNM will closely monitor this.
5. If the employee has not received 24 hours of in-service credit, the RN Manger will discuss the problem with the employee and take disciplinary action as necessary.
6. If an employee attends an outside seminar or course, they must report the following in writing to the Staff Development Coordinator (RNM).
 - a. Date of class
 - b. Topic
 - c. Number of classroom hours

VA SENTINEL EVENT REPORTING

Definition:

A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function. Examples of sentinel events are as follows:

1. Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error, *or*
2. Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility, *or*
3. Any elopement of a resident from the facility resulting in a death or a major permanent loss of function, *or*
4. Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function, *or*
5. Assault, homicide or other crime resulting in patient death or major permanent loss of function, *or*
6. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

Procedure:

1. The charge nurse will notify the Administrator/Designated Administrator and the Director of Nursing Services/Designated Director of Nursing Services immediately upon the identification of the occurrence of the sentinel event.
2. The Administrator or the Administrator Designee will notify the United States Department of Veterans Affairs Medical Center in Spokane, Washington within 24 hours of occurrence.
3. The facility investigation team consisting of the Facility Administrator, Social Services Director and the Director of Nursing Services, will review and analyze the sentinel event. This review will be documented in a written report no later than ten (10) working days following the event. A copy of this report will be forwarded to the Facility Administrator. The written report will include, but need not be limited to, the results of the investigation, steps taken to prevent reoccurrence of the sentinel event and the plan of care developed to manage the injuries and minimize the negative consequences to the injured individual(s) and facility.
4. The VA sentinel event log will be completed by the Administrator (or designee) and will be located in the Administrator's office. This log will include, but need not be limited to the resident's name, the date and time of the event, a description of the event, the person who was notified and the name of the staff member who report the event to the VA.

Revised: 06/2006

RESIDENT TRANSPORTATION/TRANSFER

Emergency Transport

1. Residents will be transported to their choice of hospitals or the VAMC in the case of an emergency.
2. Prior to transport, the licensed nurse will contact the resident's family/guardian (as appropriate) to discuss the resident's condition and to obtain information related to the possibility of transport to the hospital.
3. Prior to transport, the licensed nurse will contact the resident's physician to communicate current resident status and to obtain an order for transport as appropriate.
4. Residents with "full code" advance directives will be transported to the hospital using the following guidelines:
 - a. If resident is experiencing cardiac or respiratory distress such as difficulty breathing, chest pain, call 911 and monitor the resident until the ambulance arrives and intervene as appropriate, including providing CPR in the event of an arrest.
 - b. If resident is not experiencing cardiac or respiratory distress and does not have acutely abnormal vital signs then transport resident via the facility van or other ground transportation.
 - c. If resident is not experiencing cardiac or respiratory distress but has acutely abnormal vital signs and is unstable with conditions such as a change in the level of consciousness, short of breath, or suspected fracture then transport resident via wheelchair or gurney via the facility van accompanied by at least two staff or non-emergent ambulance as indicated.
 - d. If resident is not experiencing cardiac or respiratory distress and has acutely abnormal vital signs but is essentially stable then transport resident via wheelchair or gurney via facility van.
5. Residents with "DNR" advance directives will be transported to the hospital using the following guidelines:
 - a. If resident is experiencing cardiac or respiratory distress such as difficulty breathing, chest pain then transport via wheelchair or gurney via facility van or other ground transportation.
 - b. If resident is not experiencing cardiac or respiratory distress and does not have acutely abnormal vital signs then transport resident via the facility van or other ground transportation.
 - c. If resident is not experiencing cardiac or respiratory distress but has acutely abnormal vital signs and is unstable with conditions such as a change in the level of consciousness, shortness of breath, or suspected fracture then transport resident via wheelchair or gurney via the facility van accompanied by at least two staff or by nonemergent ambulance as indicated.
 - d. If resident is not experiencing cardiac or respiratory distress and has acutely abnormal vital signs but is essentially stable then transport resident via the facility van or other ground transportation.
6. In the event of an emergency situation, if the facility van is not available for transport within a reasonable timeframe, then nonemergent ambulance or other means of transport may be utilized.

Appointments and Transports

1. The Ward Clerk will take off order for appointment or receive appointment time and make that appointment.
2. The Ward Clerk will enter appointment into the transport calendar.
3. The calendar will be checked daily by the Transportation Aide.
4. The Transportation Aide will follow through with the appointments.
5. If there are conflicts with appointment times, the Ward Clerk will attempt to reschedule. If appointment cannot be rescheduled, the Transportation Aide will take responsibility to arrange alternative transportation.

The Transportation Aide shall pick up the resident at the nurse's station at or around the action time, unless prior arrangements have been made to change this process.

Revised 06/2006

HEALTH CARE FACILITY TRANSFER POLICY

In the event a resident is transferred to another health care facility, the following steps will be initiated:

1. Obtain discharge/transfer order from health care provider.
2. Obtain release of information from resident and/or legal representative. Send with resident (or prior to transfer) copies of the following:
 - a) Physician progress notes.
 - b) Medication Administration Record.
 - c) Physician recaps.
 - d) Current MDS.
 - e) Nursing Progress Notes.
 - f) Most recent lab and x-ray results.
 - g) Resident demographic information.
3. Notify Social Services to coordinate discharge plan.
4. Notify family of transfer arrangements.
5. Notify facility receiving resident; communicate pertinent resident health information.
6. Notify pharmacy for transfer medications/prescriptions.
7. Complete transfer form.
8. Upon transfer, annotate same in medical record to include physical condition of resident, mode of transportation, and records sent.

Revised 06/2006

TRANSFER OF ISVH RESIDENTS TO/FROM ISVH FACILITIES

To ensure that such transports are simplified and facilitated from one facility to another and that the residents be ensured continuity of care and treatment.

- 1) Travel for transfer will be arranged and executed by the resident's family. Exceptions will be handled on an individual basis.
- 2) Transfer of each resident shall take place as soon as reasonably possible after medical determination for the transfer is made. Prior to transfer:
 - a) The resident's family will be encouraged to tour the facility the resident is being transferred to, under the guidance of Social Services.
 - b) Level of care and availability of a bed will be determined by the Admission Coordinator.
 - c) Transfer arrangements will be coordinated by Social Services staff in each facility:
 - i. If no bed is available, name, family information, level of care and diagnosis will be provided. Name will be placed on the waiting list and the family will be notified by Social Services.
 - ii. If a bed is available, resident's family will be notified and the transfer will commence.
 - A. Admission date and time will be set.
 - B. Resident's name, Social Security number, diagnosis, level of care, family or persons assisting with transfer and/or next of kin's name and phone number, and any immediate medical needs resident will be transported with or will need upon arrival will be provided.
 - C. Admission Coordinator/Social Services will be responsible to notify the Director of Nursing, Physician's Assistant, Business Office, Laundry Supervisor and Charge Nurse at least 48 hours prior to transfer.
 - D. The Multidisciplinary Team will meet to discuss concerns and transfer protocol.
 - E. The RNC of the facility transferring the resident shall coordinate medications with the pharmacist. The resident will be provided with three days of medications at time of transfer. Nursing assistants will aid the resident and/or family in packing personal belongings.
 - F. The HIS of the facility transferring the resident shall check the medical chart for completeness to ensure that all required information, including documentation from other disciplines, is available at time of transfer.
 - G. The Business Office of the facility transferring the resident shall check the resident's personal account for any remaining balance, check for past-due financial charges for the current month and provide the resident or resident's family with this information. After all outstanding charges have been paid, a check or cash will be issued for any remaining funds at the time of transfer.
 - H. The Laundry Supervisor will attempt to ensure that the resident's clothing is available to the resident at the time of transfer.
 - I. Upon departure of resident from the transferring facility, Social Services will notify the Social Worker at the receiving facility of the time of departure, name of resident/residents in transit, and of any potential problem or concern relative to transfer or arrival.

- J. After transfer, any personal items and/or money remaining will be mailed to the resident or resident's family.
- 3) Upon arrival at the new facility, Social Services will assume responsibility for admission.
 - a) Resident will be transferred to the designated wing and introduced to nursing staff
 - b) Resident's medication, business record, cash, medical record and personal items will be given to the appropriate staff in each department.

Revised 06/2006

RESIDENT CARE PLANNING

Standard:

Each resident has a Resident Care Plan that is current, individualized and consistent with the medical regimen.

Policy:

- A baseline care plan is initiated upon admission of a resident.
- After nursing assessment is completed the LN completing the admission nursing assessment will add to the fast plan pertinent information and directives on how to care for the resident.
- The care plans are to be fully developed within 21 days following the resident's arrival in the facility.
- During the interdisciplinary team meetings. The team will complete the initial care plan then will review quarterly and when there is a change of condition. The team will review and update the care plan as necessary.
- Between the Interdisciplinary Team meetings each discipline will update the Resident Care Plan as needed i.e.: resident goes to hospital for stay and return's with minor changes the care plan will be updated immediately.
- Each discipline is responsible for following the established format for care planning of the long term care facility.
- Interdisciplinary cooperation should be evident in plans of care, when appropriate.
- The resident care plans are kept in the care plan books.
- All resident care plans are a part of the permanent medical record.
- The LN will update resident care plans as new physician orders are received and when new problems are identified.

Procedures

1. Assessment
 - a) A functional nursing assessments is conducted by using the admission nursing assessment and MDS.
2. Diagnosis
 - a) Resident needs are discussed and prioritized by the resident, family, and interdisciplinary team
 - b) Nursing diagnosis(s) are developed and placed in the Resident Care Plan
3. Planning and Setting Goals
 - a) Planning and setting goals are, whenever possible, a team effort by health care personnel, resident, and family.
 - b) Goals are individualized and realistic for the individual involved.

- c) Goals must be stated in terms of behavior that is both specific and measurable within a given time.
- 4. Implementation
 - a) Action or nursing intervention is specific and relates to each stated goal.
 - b) Times and actions are stated so that caregivers new to the resident can carry out care with complete continuity.
- 5. Evaluation
 - a) Progress on goal achievement is evaluated on the date set in the given time this it to be recorded in the medical record.
 - b) If the goal has been achieved the goal is yellowed out, the person making the entry will put a dc date, and place their initials.
 - c) If progress is slow, a new time frame may be established and actions adjusted to meet the resident needs.
 - d) Each problem, goal and intervention is reviewed and updated by the Interdisciplinary Team at least quarterly.
- 6. Responsibility
 - a) The resident care plan specifies the team member responsible for providing care or service and indicates how frequently specific services are being provided.

NOTIFICATION OF CHANGES

Procedure

The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification.

Compliance Guidelines:

The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification.

Circumstances requiring notification include:

1. Accidents
 - a. Resulting in injury.
 - b. Potential to require physician intervention.
2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.
This may include:
 - a. life-threatening conditions, or
 - b. Clinical complications.
3. Circumstances that require a need to alter treatment.
This may include:
 - a. New treatment.

- b. Discontinuation of current treatment due to:
 - i. Adverse consequences.
 - ii. Acute condition.
 - iii. Exacerbation of a chronic condition.
- 4. A transfer or discharge of the resident from the facility.
- 5. A change of room or roommate assignment.
- 6. A change in resident rights.
 - a. State or Federal.
 - b. Laws or regulations.

Additional considerations:

Competent individuals:

- The facility must still contact the resident’s physician and notify resident’s representative, if known.
- A family that wishes to be informed would designate a member to receive calls.
- When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident’s health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.

Residents incapable of making decisions:

- The representative would make any decisions that have to be made.
- The resident should still be told what is happening to him or her.

Death of a resident:

- The resident’s physician is to be notified immediately in accordance with State law.

Notice of room changes:

- Necessary to avoid decline in physical, mental, or psychosocial well-being.

Contact information of the resident’s legal representative or family member must be recorded and periodically updated.

Definitions:

“*Life-Threatening Conditions*”: Examples – Heart Attack or Stroke.

“*Clinical Complications*”: Examples – Development of stage 2 pressure injury, recurrent episodes of delirium, recurrent UTIs or onset of depression.

“*Need to alter treatment significantly*” means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before).

“Right to Privacy”: The facility is required to inform the resident of his/her rights upon admission and during the resident’s stay including the resident’s right to privacy (§483.10(h), F583).

If a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident’s interested family member or legal representative, if known.

If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision). F580 – Notify of Changes.
42 C.F.R. §483.25(g)(14).

8/19, revised 9/19

IV ASSESSMENTS

BLADDER ASSESSMENT AND RETRANING

Purpose:

To assess a resident's bladder continence status and determine appropriate interventions to restore or maintain normal function.

Procedure:

Bladder Incontinence Evaluation

1. The Bladder Incontinence Evaluation form will be completed on each resident within seven (7) days of admission, quarterly and on any resident identified as having a change in continence status which would benefit from further assessment.
2. The licensed nurse conducting the resident's assessment will recommend interventions based on the findings of the Assessment.
3. This completed form is located under the Assessment section in the resident's medical record.
4. Results of this assessment shall be included in the care plan as appropriate.

Bladder Retraining/Toileting Assessment

1. When a decision is made to consider a resident for participation in a retraining or scheduled toileting program, the LN will start the Bladder/toileting schedule on which will be instructions to the NAC's.
2. Once the decision is made for bladder retraining the LN will implement the retraining program for 30 days. Each week the LN will document progress, or lack thereof in the progress notes. If the resident is unable to show progress in a 30 day period then discontinue the program. The LN discontinuing the program will make recommendations for staff to follow such as routine toileting program.
3. The routine toileting program is as follows: take to bathroom upon rising, before meals, after meals and at bedtime and PRN.

Revised 4/2018

BLADDER INCONTINENCE EVALUATION

Admission Quarterly Annual Other (i.e. Sig. change)

Urinary Catheter

1. Is a Urinary Catheter inserted at present? YES NO
2. If yes specify type and size. _____
3. Is the Catheter justified medically? YES NO
If yes, what is the medical justification: _____
4. If it is not justified medically has the catheter been discontinued? YES NO
 - If not discontinued, is there a plan to discontinue the catheter? Please explain:

If catheter is present and justified medically you do not need to answer the question below.

Urinary Incontinence

1. Is the resident currently experiencing bladder incontinence? YES NO
 2. Does the resident have a history of urinary incontinence? YES NO
 3. Onset of incontinence: _____(date) Duration of incontinence: _____Days _____Months
_____Years
 4. Which form (s) of incontinence is (are) present? Identify all that apply.
 - Urge Incontinence Overflow Incontinence
 - Stress Incontinence Functional Incontinence
 - Mixed Incontinence Transient Incontinence
- *Consider Urge Incontinence if the following features are present:**
- a. Is there an overactive bladder diagnosis (abrupt urgency, frequently and nocturia)?
 YES NO
 - b. Is there a neurological component such as stroke, diabetes mellitus, Parkinson's Disease, MS, or Cerebral Palsy? YES NO
 - c. Is there a history of recurring bladder infections or urethral irritation? YES NO
 - d. Does the resident feel the need to void, but unable to inhibit voiding long enough to reach and sit on the commode? YES NO
- *Consider Stress Incontinence if the following features are present:**
- a. Is there loss of a small amount of urine with physical activity such as coughing, sneezing, laughing, walking stairs or lifting? YES NO
 - b. Is the bladder over distended? YES NO
- *Consider Mixed Incontinence if the following features are present:**
- a. Does this resident have a combination of urge incontinence and stress incontinence? YES NO
- *Consider Overflow Incontinence if the following conditions are present:**
- a. Does the resident have problems with urinary retention at present? YES NO
 - b. Does the resident have a weak stream, hesitance, or intermittency? YES NO
 - c. Problems with dysuria, nocturia, frequency, incomplete voiding, frequent or constant dribbling? YES NO
 - d. Is there a diagnosis of outlet obstruction (i.e. BPH, Prostate CA, Urethral Stricture) YES NO
 - e. Diagnosis of hypotonic bladder or neurogenic bladder? YES NO
 - f. History of Diabetes Mellitus, spinal cord injury, pelvic nerve damage from surgery or radiation therapy? YES NO
 - g. History of post-void residuals in the medical record? YES NO
 - h. History of distended bladder? YES NO

***Consider Functional Incontinence if the following conditions are present:**

- a. Is there physical weakness or poor mobility/dexterity due to poor eyesight, arthritis, deconditioning, stroke or contractures? YES NO
- b. History of CHF or obesity that contributes to weakness or limits mobility? YES NO
- c. Cognitive problems such as confusion, dementia, or an unwillingness to toilet? YES NO
- d. Is the resident medicated with sedatives or hypnotics? YES NO
- e. Are there environmental impediments that make it difficult to reach a toilet or commode? YES NO

***Consider Transient Incontinence if the following conditions are met:**

- a. Is there a history of delirium, infection, urethritis or vaginitis? YES NO
- b. Is the resident medicated with sedatives, hypnotics, diuretics, or anti-cholinergic agents? YES NO
- c. Use of caffeine? YES NO
- d. Is mobility restricted? YES NO
- e. History of significant constipation or fecal impaction? YES NO
- f. History of prolapsed uterus or bladder? YES NO
- g. History of bladder spasms? YES NO

Urinary Tract Infections

- 1. Is there a history of persistent or recurrent UTI'S?
- 2. Does the resident have a urinary tract infection at present? YES NO

*Consider Urge Incontinence, Mixed Incontinence or Transient Incontinence if answer above is yes.

Intake and Output

- 1. Average Fluid Intake in 24 hour period: _____
- 2. Average Fluid Output in 24 hour period: _____
- 3. Has there been significant changes in fluid intake or output levels recently? YES NO

*Consider Overflow Incontinence or Transient Incontinence if answer above is yes.

Medications that may affect continence:

- 1. Is the resident taking medications to treat incontinence? YES NO
- 2. Is the resident taking anti-cholinergic that may cause urinary retention or Overflow Incontinence? YES NO
- 3. Is the resident taking diuretics that may cause urgency, frequency, or Overflow Incontinence? YES NO
- 4. Is the resident taking narcotics or alpha-adrenergic agonists that may cause urinary retention in men? YES NO
- 5. Is the resident taking alpha agonists that may cause stress incontinence in women? YES NO
- 6. Is the resident taking Calcium Channel blockers that may cause urinary retention? YES NO

Skin Condition

- 1. Does the resident have a pressure ulcer or other skin conditions that could be aggravated by urinary incontinence? YES NO
- 2. Does the resident have the potential of developing complications such as skin irritation or breakdown? YES NO

Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet:

- Grab Bars
- Raised or low toilet seats
- Inadequate lighting
- Fear of Falling
- Availability of urinal
- Use of bed rails or restraints
- Distance to toilet/commode
- Restrictive clothing

Cognitive Skills

- 1. Is the resident able to comprehend and follow through on education and instructions? YES NO
- 2. Is the resident able to identify the urinary urge sensation? YES NO
- 3. Is the resident able to respond to prompts to void? YES NO

*If responses to the above questions are positive, consider implementing the Bladder Training Program.

Evaluation for bladder program potential

Able to participate in bladder retraining program:

- Evaluation period: _____ to _____
- Plan: _____

Unable to participate in program:

- Reason (s): _____

Resident chooses not to participate in program:

- Reason (s): _____

Nurse Completing Assessment: _____ Date: _____

DOCUMENTATION /ASSESSMENT RECOMMENDATIONS FOR RESIDENTS EXPERIENCING CHANGE IN CONDITION OR ACUTE ILLNESS

In the event a resident experiences a change in condition or acute illness, the following may assist in the assessment and documentation of the resident's status. This information may be included in the nurses' notes and/or when communicating the resident's condition to his/her primary physician.

1. Chief Complaint
2. Vital Signs +O₂ Sats
3. Recent medication changes
4. Medication allergies/history of medication adverse side effects
5. How long/time frame since change/illness was identified.
6. Status: slow deterioration, rapid deterioration
7. Lab values recent abnormal/critical lab results
8. Mental Status changes: e.g. oriented, alert, confused, comatose, cooperative, uncooperative, withdrawn, agitated, lethargic, anxious, weepy
9. System review (as applicable)
 - a) Respiratory
 - i. Lung sounds: abnormal lung sounds and location
 - ii. Nature of respirations: depth and rate, use of accessory muscles, sounds audible without stethoscope, dyspnea on exertion and/or at rest.
 - iii. Cough: productive or nonproductive, congested or dry, frequency, description of any sputum (color, consistency, amount)
 - iv. Hydration: amount of fluid intake, encouragement needed to take fluids
 - v. Pain: description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
 - b) Cardiovascular
 - i. Pain: description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
 - ii. Edema: site, pitting or non-pitting
 - iii. Heart sounds: rate and rhythm
 - iv. Resident symptoms: syncope, fainting, flutters, other sensation in chest
 - v. Lung sounds: abnormal sounds and location
 - vi. Respirations: depth and rate, use of accessory muscles, dyspnea on exertion and/or at rest
 - vii. Cough: productive or nonproductive, congested or dry, frequency, description of any sputum (color, consistency, amount)
 - viii. Medications administered: e.g. nitrostat, results
 - c) Gastro-intestinal
 - i. Nausea/vomiting: frequency, description of emesis (amount, color, consistency)
 - ii. Diarrhea: frequency, description of stool (amount, color, consistency)
 - iii. 3. Medications administered: e.g. MOM, Mylanta – results
 - iv. Pain: description of pain (aching, stabbing, throbbing, burning), location, constant/ intermittent, severity.
 - v. Turgor evaluation: mucosa, skin
 - vi. Skin assessment: dry, cool, clammy, pale

- d) Genito-urinary
 - i. Pain : description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
 - ii. Urinary: frequency/urgency
 - iii. Change in urinary continence
 - iv. Fluid: intake versus output
 - v. Urine: color, odor, sediment
- e) Central Nervous System
 - i. Change in functional status: weakness, paralysis, spasticity, flaccidity, description, define extremity(ies) affected
 - ii. Aphasia: if present - degree of impairment, expressive or receptive or both
 - iii. Swallowing: if affected, food or fluid consistency impacted
 - iv. Responsiveness: any changes, describe response to pain, eyes open or closed, restlessness, etc.
- f) Musculo-skeletal
 - i. Pain: description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
 - ii. Change in level of activity/mobility
 - iii. Change in alignment: hip/leg, shoulder/arm
 - iv. Pain medication administered: results
 - v. History of falls
 - vi. Diagnosis impacting musculo-skeletal function

DENTAL SERVICES ASSESSMENT

1. All residents will be evaluated by a dentist annually.
2. Requests for dental services shall be ordered by the resident's primary physician and the facility shall make arrangements for dental services through either the resident's preferred physician.
3. Identified dental problems are treated as follows:
 - a) Emergency if there is acute pain present.
 - b) Resident in Discomfort if there are sore gums, serious dental cares, etc.
 - c) Routine if no acute problems are identified.
4. If a resident refuses treatment, it is noted in the medical record by the medical provider or licensed nurse.
5. Dentures shall be labeled by the unit Senior Certified Nursing Assistant or designee.
6. The resident's care plan shall be updated by the RN MDS Coordinator or designee as applicable.

DIALYSIS PROCEDURE

To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This procedure pertains to dialysis.

Procedure:

1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures.
2. The facility will utilize a systematic approach for the management of special needs, including efforts to identify risk: stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate.
3. If necessary, the facility will assist residents in making appointments with a qualified person or facility and arranging for transportation to and from such appointments. Where necessary, a doctor's order will be received that includes the name of the dialysis provider, frequency and location.
4. The facility will communicate relevant information with outside providers to ensure safe, continuous care of the resident. A "Communication with Dialysis Centers" form will be used pre, during, and post dialysis.
5. The comprehensive assessment process will be utilized for identifying needs and risk factors or conditions that increase risks to the resident's quality of life or medical condition.
6. A person-centered care plan will be developed, based on specific factors identified in assessments and physician orders, and in accordance with the resident's goals and preferences.
7. Medical conditions will be monitored and managed to prevent complications.
 - a. The attending physician will coordinate with the dialysis team for the overall care and treatment of the resident's medical conditions.
 - b. RNs and LPNs will participate in the management of medical conditions by following physician orders, assessment of residents and reporting changes in condition to the resident's physicians.

- c. Interventions will be modified in a resident's plan of care as needed.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Disease Control and Prevention, *Dialysis Safety, Infection Prevention Tools* (Reviewed September 25, 2017). <https://www.cdc.gov/dialysis/prevention-tools/audit-tools.html>

03/2018, 4/2020

FALL ASSESSMENT

Procedure:

1. Residents admitted into the Idaho State Veterans Home-Pocatello will have a complete Fall Risk Assessment completed by LN staff within 24 hours of admission.
2. A quarterly Fall Risk Assessment will be completed thereafter by the MDS Coordinator (or designee). This assessment will coincide with the resident MDS schedule.
3. A Fall Risk Assessment will be completed when a resident has had a fall of any kind. The LN (or designee) assigned to the resident will be responsible for the completion of this assessment. This assessment must be completed within 4 hours of the fall.
4. The Fall Risk Assessment is composed of eight clinical condition parameters. They are as follows:
 - a) Level of consciousness/mental status with possible scores of 0, 2, and 4.
 - b) History of falls (past 3 months).
 - c) Ambulation/Elimination status.
 - d) Vision status
 - e) Gait/Balance.
 - f) Systolic Blood Pressure
 - g) Medications.
 - h) Predisposing Diseases.
5. The Licensed Nurse completing the assessment must complete in Point Click Care.
6. The Licensed nurse completing the assessment must also make an entry into the medical record nursing progress notes that (for example): The Admission/Quarterly/Change in condition fall assessment completed this date, with a score of eight (8). Interventions of have been placed on care plan, 24 hour sheet and reported off to on-coming shift.

Falls Scoring Guidelines for Suggested Care Plan Interventions is as follows:

1. Score of 4 - 6 = Low Risk Category.
 - a) Use careful Nursing judgment and determine if care plan interventions are needed.
2. Score of 7 – 9 = Medium Falls Risk Category.

- a) Position resident in highly visible area.
 - b) Bed/Wheelchair alarm may be used/implemented,
 - c) Consult with rehab aide for positioning devices available or needed.
 - d) Consider environmental adaptation ie: proper w/c if applicable, padding on floor etc.
 - e) Q 1 hours checks when not in highly visible area for safety and needs ie: physical needs such as toileting.
3. Score of greater than 10 = High Falls Risk Category
- a) All interventions listed above for Medium Falls Risk
 - b) Position resident near Nurse's Station, Activity or staff member when out of bed.
 - c) Q 15-30 minute checks when in bed.
 - d) Assess need for modified environment (padding on floor, wheels off bed etc.)
 - e) One to one staffing during times of increased activity as indicated by Fall committee,
 - f) Referral to P.T/O.T. for screen as indicated.

Revised 3/18, 3/19

NEUROLOGICAL ASSESSMENTS

Policy:

Residents that have a fall with a suspected head injury such as: bruise, scrape, lying in suspected position suggestive of hitting head, or any other condition which warrants neurological checks will have a Neurological Assessment completed.

Procedure:

Each resident that has a suspected head injury following a suspected fall such as a bruise in the head area scrape, abrasion, c/o of hitting head or in a suggestive position of hitting head in a fall, or any other condition which warrants neurological checks will have a Neurological Assessment completed immediately following initial nursing assessment after incident. Assessment is to be completed on the attached form by a Nurse. All actual/suspected head injuries are to be reported to MD within 24 hours. If actual head injury with positive neurological assessment, the MD will be immediately notified. When assessment is initiated the form will be kept at the Nurses Station.

Procedure is as follows:

1. Neurological assessment Q 15 minutes X 8
2. Neurological assessment Q 30 minutes X 2
3. Neurological assessment Q 1 hour X 4
4. Neurological assessment Q shift of 8 hours until approximately 72 hours have elapsed and resident is stable.

Revised 5/2018, 9/2019

HEARING SERVICE

Request for hearing/audio logical services shall be ordered by the resident's physician and the facility shall make arrangements for hearing/audio logical services through either the VAMC or the resident's preferred provider.

Revised 06/08/06

MDS RESIDENT ASSESSMENT INSTRUMENT (RAI)

1. OVERVIEW OF THE RAI:

Providing care to residents of long term care facilities is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from ALL disciplines to develop Individualized Care Plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information; a resident's strengths and needs which must be addressed in an individualized care plan. The process assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. The Care Plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being.

2. TOOLS TO LEARN THE RAI PROCESS

The Resident Assessment Instrument —user guide is the MDS BIBLE. All team members need to have a manual and familiarize themselves with this manual to complete the RAI process. The RAI process is completing the Minimum Data Set (MDS), Care Area Assessments (CAA), and the resident Plan of Care. The process looks somewhat like the following:

Assessment → Decision Making → Care Plan → Care Plan → Evaluation
(MDS/Other) (CAA) (Develop) (Implement)

3. INTERDISCIPLINARY TEAM (IDT) STRUCTURE AND PROCEDURE

- a) The MDS Coordinator (s) will oversee and direct the facility's MDS process.
- b) The MDS Coordinator (s) will provide a schedule to teams as to which residents are due, the type of assessment to be done and when the assessments/RAI components are due to assure the facility is maintaining compliance with timeframes.
- c) In the event of a Significant Change In Status, a comprehensive assessment will be done with any major decline or improvement which meets the following criteria:
 - i. Condition will not normally resolve itself without further interventions, is not self-limiting (for declines only).
 - ii. Condition impacts more than on area of resident's health status (Refer to RAI manual that will give more specific information).
 - iii. Condition requires interdisciplinary review/revision of the care plan.

- d) Assessments **MUST** be complete by the timeframes outlined by the RAI manual. There are no exceptions. This is needed to stay in compliance with regulations as well as transmission.
- e) The entry tracking record will be completed by the MDS Coordinator.

4. DISCIPLINES' RESPONSIBILITIES FOR RAI PROCESS

- a) Each discipline will be assigned the following sections:
 - i. Nursing: A0100-A0410, A1600-A2400, B0100-B1200, G0110-G0120, G0600-G0900, H0100-H0600, I0100- I0800, J0100, J1900, L0200, M0100-M1200, N0300-N0400, O0100- O0300 O0400D-F, O0600-O0700, P0100, V0100A-C, X, Z.
 - ii. Social Services: A0500-A1550, C0100-C1600, D0100-D0650, E0100-E1100, Q0100 - Q0600, V0100 D-F.
 - iii. Dietary: K0100-K0700.
 - iv. Activities: F0300-F0800.
 - v. Therapy: 00400A-C (Therapy will provide printout of therapy minutes to MDS Coordinator who will input into computer and attach to MDS).
 - vi. Restorative: G0300-G0400, O0500. (Care Tracker report will be pulled by MDS Coordinator for Input onto MDS).
- b) Associated CAA's for each discipline will be the following (to be completed no later than the date assigned by the MDS Coordinator which will be followed as mandated):

Nursing:

- #1-Delirium
- #3-Vision
- #4-Communication
- #5-ADL Function/Rehab Pot.
- #6-Urinary Incontinence
- #11-Falls
- #13- Feeding Tubes Referral
- #14-Dehydration & Fluid
- #15-Dental Care
- #16-Pressure Sores
- #17-Psychotropic Drug Use
- #18-Physical Restraints
- #19-Pain

Social Services:

- #2-Cognitive Loss
- #7-Psychosocial well-being
- #8-Mood State
- #9-Behavior
- #17-Psychotropic Drug Use
- #20-Return to Community

Activities:

- #10-Activities

Dietary:

- #12-Nutritional Status

5. ADDITIONAL MDS DUTIES TO BE COMPLETED BY RN MANAGERS/MDS NURSE

- a) Nursing will compile, complete, and review Braden skin, fall risk, restraint reduction, pain, bowel & bladder, smoking, self-med assessments if applicable on a quarterly basis. Focus Charting will need to be set up by RN Manager/MDS Coordinators to be completed by LN's during the seven (7) - day observation period for MDS's.
- b) Restorative will complete and submit walking and functional limitation In ROM assessment that will be reviewed by the Restorative Nurse and cosigned.
- c) Therapy will complete and submit for section O0400 A-C number minutes/days of ST, OT, PT on the therapy form and give to MDS Coordinator/MDS Nurse.

PAIN ASSESSMENT/MANAGEMENT

Purpose:

Each resident who experiences pain will have a comprehensive assessment of that pain and will have a treatment plan established to treat his or her pain.

- Resident preferences must be respected when deciding on methods to be used for pain management. Family members should be involved when appropriate.
- A licensed nurse must carry out pain assessments and reassessments.

Procedure:

1. Considerations:

- a. A comprehensive Pain Assessment shall be done upon admission, and as identified appropriate in the event of a change in the resident's pain med regimen and/or frequency, severity of pain.
- b. Unrelieved pain has negative physical and psychological consequences, including the potential for threatening functional ability.
- c. Medications used to treat chronic pain should be given on a regularly scheduled basis.
- d. Medication for breakthrough pain is often necessary when treating chronic pain.
- e. Residents receiving narcotic analgesics sometimes become tolerant to their medication dose and need an increased dose; however, actual physical addiction is rare.
- f. The common side effects of narcotic analgesics can usually be managed and do not require discontinuing the narcotic.
- g. The same pain control measures used for residents who are able to communicate should be used for residents unable to communicate their pain due to severe dementia, aphasia, or other causes.
- h. Optimal use of pain control measures depends on cooperation between members of the health care team.
- i. If resident demonstrates or voices pain during care interventions then staff shall immediately report status to licensed nurse for follow-up.

Process:

- a. Perform a pain assessment utilizing/completing the pain assessment located in Point Click Care.
 - a) Whenever possible, obtain all information directly from the resident. When the resident is unable to participate, obtain information from caregivers and family members.
 - b) In some cases, use behavioral cues to gather information.
- b. Review the resident's current pain medication regimen to determine the following:
 - a) Name of drug, dose, and frequency ordered.

- b) How long the resident has been on this medication.
- c) Degree of relief experienced from this medication.

Managing Pain:

1. If resident receives a regularly scheduled pain medication then pain shall be assessed a minimum of every shift and interventions implemented as appropriate.
2. When treating pain, start with a drug appropriate to the resident's current level of pain.
3. Resident's with wounds/incisions, etc. (excluding skin tears), needing dressing changes will be assessed 30-60 minutes prior to dressing change for need for pain medication or other pain relieving intervention.
4. Consider a regularly scheduled pain medication to achieve pain control – typically a PRN medication of the same type is available for breakthrough pain + a PRN medication of a lesser dosage/type may also be available.
5. Monitor to ensure that total dosages (regularly scheduled + PRN) do not exceed allowable daily dosages. (e.g., Tylenol should not exceed 9 {325mg.} tabs (or 3000 mg) in 24-hour period.)
6. Assess the resident's pain when starting a regularly scheduled pain medication, when the dosage has changed, or if the drug has changed. (Alert Charting)
7. Assess and document pain using an appropriate pain scale prior to and after administration of PRN analgesics. Document on PRN Pain Management Tool (located behind PRN med sheet).
 - a) Document level of pain: Level 0-10. If resident unable to verbalize, then evaluate pain relief using observable/behavioral pain cues.
 - b) To evaluate effectiveness, use the pain rating scale (0-10) if appropriate or document results of the pain medication based on resident's observable and behavioral cues.
8. Whenever the resident demonstrates or voices pain, or if the resident uses an increasing number of PRN pain med doses, or if pain is not decreased following administration of pain medicine, or if pain rating remains 6-10, then notify the attending physician as appropriate.
9. Management of the side effects of analgesics is the joint responsibility of the attending physician and the nursing staff.

MDS Process:

1. Residents will be assessed for pain and coded appropriately on the MDS.
2. If a resident is coded on the MDS for moderate pain and this is a change in pain severity, then the RN Manager or DNS shall be notified.

Resident Care Plan:

1. The resident care plan is updated as needed. Documentation in the nurse progress notes is done according to protocol.

Revised 02/18

SKIN ASSESSMENT PROGRAM

This procedure is to ensure timely and accurate resident skin assessments; to evaluate resident(s) at risk for developing skin problems; to evaluate effectiveness of wound treatments and other wound healing interventions.

1. On a weekly basis the skin condition of each resident will be assessed by a licensed nurse and the results documented in PCC.
 - a. Typically the skin assessment will be conducted on the same day each week and will coincide with the bathing process.
2. On admission and on a quarterly basis each resident shall be evaluated for potential for skin breakdowns using the Braden Scale – for Predicting Pressure Sore Risk in Point Click Care (PCC) assessments tab.
 - a. Admission assessment (head-to-toe skin assessment) will be completed by the admitting nurse (or designee) within six (6) hours of admission. (skin integrity assessment is located under admission nursing assessment in PCC). If the resident has a current pressure ulcer and/or a history of prior healed pressure ulcer, then the admitting nurse or skin wound nurse shall document, in detail, the status of the site(s).
 - b. Assessment will be completed by the admitting nurse or charge nurse or designee (see Braden Scale Assessment).
 - c. Quarterly assessments (Braden Scale) will be completed by the MDS Coordinator or designee, in conjunction with the MDS schedule.
3. All identified skin integrity issues/problems (see #1 & 2) will be communicated to the skin wound nurse and/or charge nurse for follow-up.
4. Skin/Wound nurse will evaluate residents who are experiencing a change of condition, those on terminal comfort care, and any other referred resident for the purpose of determining appropriate interventions to prevent skin breakdown.

Quality Assurance

1. The quality Assurance Committee will monitor the incidence and prevalence of pressure ulcers.
2. The committee will periodically conduct monitoring of skin/wound issues and determine compliance with the above problems.
3. The Director of Nursing Services and the facility leadership team will ensure procedures are consistent with current standards.

5/2018

SKIN CONDITION PROCEDURE

Purpose: The following procedure (s) will be followed when a skin condition is identified.

Skin Ulcer/Wound: Skin ulcer definitions are included to clarify clinical terms related to skin ulcers. At the time of the Skin assessment and diagnosis, the LN is expected to document the clinical basis (e.g. underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

1. Definitions of the different ulcers:

- a) Arterial Ulcer: An ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis, inadequate blood supply to the extremity may initially present as intermittent claudicating Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders, or significant vascular disease elsewhere, (e.g. stroke or heart attack). The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g. top of the foot or toe, outside edge of the foot) The wound bed is frequently dry and pale with minimal or no exudates. The affected foot may exhibit diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down or increased pain when elevated, blanching upon elevation, delayed capillary till time, hair loss on top of the foot and toes, toenail thickening.
- b) Diabetic Naturopathic ulcer: Requires that the resident be diagnosed with diabetic mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs (on the foot, e.g. at mid foot and the ball of the foot over the metatarsal heads, or on the top of toes with Charcot deformity.
- c) Venous Insufficiency Ulcer: (known as “stasis ulcer”) is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are to the most common vascular ulceration and may be difficult to heal, may occur off and on for several years and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial and may have a minimal to copious serous drainage unless the wound is infected. May experience pam which may be increased when the foot is in a dependent position, such as when a resident is seated with feet on the floor

Pressure Ulcers

The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

Definition of a Pressure Ulcer:

A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.

When a resident is admitted with or develops a pressure ulcer the following steps must be taken: (This is also applicable with other identified ulcers as explained above.)

- 1) A complete assessment must be done, this assessment must contain the following:
- 2) Factors that influenced its development e.g. disease process(s)
- 3) Differentiate the type of ulcer.
- 4) Determine the ulcer's stage using the following definitions:
 - a) Stage I - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: Skin temperature (warmth or coolness), Tissue consistency (firm or boggy), sensation (pain, itching) and/or a defined area of persistent redness in lightly pigmented skin.
 - b) Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
 - c) Stage III - Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue
 - d) Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.
NOTE: if Escher and necrotic tissue are covering and preventing adequate staging of a pressure ulcer, the RAI User's Manual Version 2 instructs the assessor to code the pressure ulcer as a Stage IV.
 - i. Describe the ulcer's characteristics.
 - ii. Determine if infection is present.
 - iii. If pain is present.
 - iv. Treatment indicated.
 - v. Interventions In place for prevention or needed to promote healing.
 - vi. Nutrition/skin committee notified.
 - vii. MD notified.
 - viii. Family notified and in agreement with treatment.
5. Each pressure ulcer shall be assessed no less than weekly with results documented in a pressure ulcer weekly assessment.

6. Residents with a pressure ulcer will be referred to NAR for nutritional evaluation.

Revised 3/18

SKIN CHECK AND BATH PROCEDURE

Skin checks are assigned weekly and baths are assigned twice a week and will accommodate resident preference as available. The schedule is for Day and Evening Shifts and are placed in the Bath Book. The schedule will be on the TAR and the Charge Nurse will make assignment of bath and skin in the daily flow sheet for the shift. R in PCC. The CNA completing the resident bath will notify the LN assigned for a skin check. The CNA will check off the completion of bath in the POC and on the original assignment sheet. The Charge Nurse will monitor as needed to assess completion of the assigned duties. If resident refuses or doesn't get the bath for other extenuating circumstances the LN will be notified and the bath will be rescheduled. Skin checks will be completed when possible on the assigned day.

SMOKING POLICY AND PROCEDURE:

I. Purpose

Smoking is the leading preventable cause of disease, disability, and premature death in our society. Work-site smoking policies and programs play an important role in decreasing the prevalence of smoking and smoking-related diseases. It is the intent of the Idaho Division of Veterans Services to promote public health and protect the rights of both Smokers and Nonsmokers to ensure safe practices are exhibited.

II. Guidelines

In accordance to the Idaho Division of Veterans services guidelines and to further ensure the safety of Idaho State Veterans Home residents and staff against hazards related to smoking, the following will apply:

- A. Smoking is only allowed in designated smoking areas. These areas are designated as such.
- B. Idaho State Veterans Home residents may not smoke indoors except for the designated smoking area.
- C. Idaho State Veterans Home residents who smoke will be assessed upon admission and as needed to determine the appropriate level of supervision required during smoking.
- D. Noncombustible receptacles will be provided at each designated smoking area.
- E. All staff has the responsibility of ensuring these policies are enforced at all times and according to the resident's assessment.
- F. The designated smoking areas include: INDOOR- Across from the nurses' station, OUTDOOR- covered awning in front of the facility, the covered gazebo off the South Hallway, and covered patio adjacent the chapel on the East Hall.
- G. All resident smoking materials will be kept at the nurses' station when not in use. Only flameless cigarette lighters will be allowed in the facility (no flames will be allowed).
- H. The Smoking Agreement will be completed by the Admissions Coordinator/designee at time of admission.
- I. The Smoking Committee will meet regularly to discuss concerns, completed assessments and other issues that need to be addressed.
- J. Residents' care plans will reflect the current status of the residents ability to smoke
- K. Cigarettes are the financial responsibility of each resident. Staff will assist with purchasing cigarettes when arrangements are made in advance.
- L. Visitors must also abide by smoking in the designated smoking areas. The facility reserves the right to limit the number of smokers at the indoor smoking area.

III. Classifications

Residents will be assessed for their safety and ability to smoke. It will not be allowed for any resident to keep with them their own smoking material. Based on the responses and consultation with facility staff, the Social Worker/designee will determine the appropriate level of supervision.

A. Independent

- 1. Residents must show steady cognitive ability, good judgment, manual dexterity and adequate mobility to smoke independently. They consistently demonstrate safe smoking behavior within assessment and the policies of the facility.
- 2. These residents will not require supervision.
- 3. They may light their own cigarette.
- 4. All smoking materials will be kept at the nurses' station and distributed according to above policy.

B. Assistance required (See individual care plan)

These residents may need assistance to:

- 1. Ensure their oxygen is turned off and that the portable oxygen device is not taken into the smoking area.
- 2. Don a smoking apron, if required by care plan.
- 3. Smoke in designated areas only.

4. Light and extinguish smoking materials appropriately.
- C. Unable to smoke safely
1. Residents who require extensive supervision will not be allowed to use flammable smoking materials.
 2. These residents will be offered alternative nicotine therapy including but not limited to nicotine patches, gum, electronic cigarettes. (CMS in S & C: 2-04-NH have deemed, “e-cigarettes are not considered smoking devices, and their heating element does not pose the same dangers of ignition as regular cigarettes.”)

IV. Administration:

- A. The Smoking Committee is comprised of Social Services, Administrator, Director of Nursing Services, Senior Certified Nursing Assistant, MDS Coordinator and Ward Clerk.
- B. The purpose of the Smoking Committee is to ensure residents have safe access to smoking materials and other residents are not negatively impacted by smoking policies.
- C. The Smoking Committee shall meet at least quarterly and as needed to review smoking policies and concerns.
- D. The Smoking Committee Chair may be reached after hours re: questions, concerns or infractions. If they are not reached, the RN charge nurse will make a decision and refer it to the committee.

V. Violations:

- A. Violations of any portion of this policy may be grounds for disciplinary actions including but not limited to: temporary or permanent loss of smoking privilege, discharge or transfer from the home (per IDAPA 21.01.01 may be “necessary to protect the health and safety of other residents or staff”).
- B. Permanent decision for violations will be discussed by the Smoking Committee.
- C. Contraband searches may be necessary to ensure resident safety.
- D. Reassessment and reclassification may be necessary with each infraction and could happen at any time.

Signature

Date

Facility Representative

Date

VISION SERVICES/ASSESSMENT

1. Requests for optical services shall be ordered by the resident's primary physician and the facility shall make arrangements for vision/optical services through either the VAMC or the resident's preferred provider.
2. Eye glasses shall be labeled by the unit Senior Certified Nursing Assistant or designee.
3. The resident's care plan shall be updated by the MDS Coordinator or designee as applicable.

06/06

MINI MENTAL STATUS (MMS) FOLSTEIN

A Mini Mental Exam will be completed upon admission on each resident. Then annually on each resident.

BOWEL MANAGEMENT PROTOCOL

Purpose

The purpose of this program is to promote adequate and consistent elimination patterns.

Procedure:

1. A resident's bowel movement(s) will be documented in Point of Care every shift.
2. The NOC shift nurse will initiate the bowel maintenance worksheet and begin interventions as appropriate and pass on the bowel maintenance worksheet to the oncoming shift nurse.
3. The licensed nurse will write/implement standing orders (if no PRN orders are already in place) for progressive bowel elimination intervention.
4. Each nurse will pass along updated bowel maintenance worksheet through each shift to the NOC shift nurse and the NOC shift nurse will then revise, add on, and delete names as appropriate.
5. NOC shift nurse will also add a one-time alert order to PCC notifying staff to initiate bowel protocol. If the resident is on the list again the following day for no results another one-time alert order will be placed in PCC and will repeat daily until resident has results.
 - Step 1 – Bisacodyl tab give 10 mg by mouth as needed for constipation if no BMx48-72 hours.
 - Step 2 – Bisacodyl suppository – insert 1 suppository rectally as needed for constipation if no BMx12-24 following Bisacodyl tabs administration.
 - Step 3 – Fleet Naturals cleansing enema – insert one dose rectally as needed for constipation if no BMx12-24 hours after Bisacodyl suppository. May repeat X1 if no results in 12-24 hours.
6. Completed bowel maintenance sheets will be given to the DNS.
7. MD will be notified of residents who experience frequent constipation for consideration of adding scheduled medications as appropriate.

Revised 02/2013, 03/2013, 04/2018

NUTRITION SCREEN FOR NUTRITION AT RISK

The dietitian reviews the following criteria each month to determine which residents are considered to be nutritionally at risk each month. The Nutrition at Risk Committee meets monthly to discuss the identified residents and interventions to implement to resolve concerns. The minutes and interventions discussed at the meeting will be given to the MD as well as all the committee members to ensure the interventions are carried out in a timely and effective manner.

Nutrition Screening Criteria:

+/- 5% in one month

+/- 7.5% in 3 months

+/- 10% in 6 months

20% below ideal body weight OR BMI 20.5

Normal weight but have:

Pressure or diabetic ulcers (new or non-healing) as identified by weekly wound report

Oral/fluid intake is below estimated needs for 3 consecutive days or the monthly average as provided by food service reports. (A spreadsheet of each resident's needs will be provided by dietitian to dietary staff)

Low Hgb defined as a drop greater than 2 grams within the last 2 months or since the last lab draw.

Significant change (as determined by a significant change MDS being performed)

New tube feeding

Additional residents may be identified as nutrition at risk based on the nutrition at risk committee's judgement.

Residents who are not considered nutritionally at risk will have a progress note put in their chart each month by the dietitian to verify that these criteria have been reviewed.

Implemented 7/2016

(Signed by Dr. W. Wiley 7/2016)

RDN ORDER WRITING PRIVILEGES AND THERAPEUTIC DIET ORDERS

Procedures:

To assure that residents receive nutritional care and therapeutic diets in the appropriate form and/or the appropriate nutritive content, as prescribed by a physician or Registered Dietitian Nutritionist (RDN). These orders will support the resident's treatment, plan of care, in accordance with his/her goals and preferences.

Explanation and Compliance Guidelines

1. The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet and other nutritional interventions to the extent allowed by State law.
2. Should the attending physician delegate the prescribing of therapeutic diets and other nutritional interventions, he or she will supervise the dietitian and remain responsible for the resident's care.
3. Therapeutic diets will be provided to residents in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team to support the treatment and plan of care. Therapeutic diets may be considered if the resident has inadequate nutrition or nutritional deficits as evidenced by weight loss or other medical problems. All therapeutic diet orders will be documented in the resident's medical record and communicated to dietary.
4. Nursing services is responsible for notifying the dietitian when a nutritional problem has been identified (i.e., weight loss, pressure ulcer, eating problem, etc.).

Delegation Guidelines

1. The attending physician may delegate to qualified dietitians, the responsibility to alter, change, or modify therapeutic or texture modified diet orders.
2. The attending physician may also delegate to qualified dietitian, the following:
 - a. Oral nutritional supplements
 - b. Measurement of Height and Weight
 - c. Initiation, order modification or discontinuation of enteral feedings
 - d. Initiation or discontinuation of fluid restrictions
 - e. Initiation or discontinuation of calorie counts
 - f. Implement Medical Nutrition Therapy
 - g. Order medical laboratory tests related to nutritional therapeutic treatments
 - h. Initiate, implement and adjust pharmacotherapy plans, which may include multivitamins, minerals, enteral and parenteral nutrition therapy
 - i. Perform nutrition-focused physical assessments to evaluate for nutritional risk

12/28/18

RESIDENT WEIGHTS/NUTRITIONAL EVALUATION

Resident Weights

5. Upon admission, the resident will be weighed, and then weighed daily for an additional 3 days and then weighed weekly.
6. Weights will typically be obtained on each resident once a week, typically on scheduled bath day by the bath CNA.
 - a. Weights will be recorded on the resident's weight sheet.
 - i. The original weight sheet will be reviewed by the RN Manager and given to the unit Ward Clerk.
 - ii. Completed weights will be entered into the computer by the ward clerk. Weights are retrieved and reviewed by RD/DSM.
 - b. The Ward Clerk will enter the weight into each resident's medical record.
7. Re-weights will be obtained on each resident whose previous month's weight, compared with the current weight, is plus (+) or minus (-) five (5) pounds.
8. Re-weights will be obtained on each resident whose previous week's weight, compared with the current weight, is plus (+) or minus (-) three (3) pounds.
9. Re-weights will be obtained upon discovery of the weight differences and both weights will be recorded onto the resident's weight sheet.
10. On a re-weight, the weight closest to the previously recorded weight will be used as a basis for further interventions.

Evaluation:

Although a resident's weight loss or gain can be identified through obtaining weights there are other means to help identify those residents who might be at nutritional risk. The following are examples of conditions that may warrant further referral/consultation:

1. Review of meal percentages indicates a decrease in consumption either universal or consistent with a specific meal(s).
2. Resident's clothing appears looser, baggier than previously.
3. Resident complaints of problems that may impact ability to consume food e.g. sore gums, ill-fitting dentures, nausea, poor appetite.
4. Resident has a newly diagnosed medical condition that may contribute to weight loss/gain such as CHF, dysphagia, cancer, diabetes, CVA, decubitus ulcer, abnormal lab values, etc.

Revised 3/2013

SIDE RAIL ASSESSMENT

Purpose:

To evaluate the use of side rails to determine appropriateness for resident's needs.

Procedure:

1. Upon admission, a resident will be evaluated for need of bedside rail(s) using the established facility Side Rail Assessment form in PCC.
2. Subsequent assessments will be conducted with the addition or subtraction of side rail(s), a change in the condition of a resident, and quarterly per the MDS schedule.
3. Results of the assessment will be care planned and physician orders written (as appropriate) if restraining.
4. Residents using side rails determined to be physical restraints will be referred to the physical restraint reduction committee.

Guidelines for completion of Side Rail Assessment Form

Per licensing and Certification recommendations, please consider the following when completing the assessment.

1. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. If this is the situation upon assessment, refer to physical restraint reduction committee for further evaluation.
2. If a resident has no voluntary movement, need to determine if there is any appropriate use of side rails.
3. Assessment needs to clearly identify the medical symptom being treated by the use of side rails. (Lack of safety awareness due to dementia is not acceptable in itself.)

Revised 01/15

Policy and Procedure for Monitoring Psychotropic Medication Side Effects

Protocol for Aims Testing

Policy/Purpose:

The use of medications in any population involves potential risks, as well as benefits. Residents who are prescribed antipsychotic medications, amoxopme (antidepressant, brand name Ascendin) and Antiemetic agent Reglan shall be regularly and systematically assess and evaluated for possible adverse side effects. The assessment tool used is the AIMS (Abnormal Involuntary Movement Scale).

Procedure:

AIMS testing will be completed on all residents within 7 days of their admission date to establish a baseline. Residents prescribed any antipsychotic medication, amoxopine (ascendin), or Antiemetic agent Reglan will be assessed and evaluated for adverse side effects with an AIMS prior to first dose of ant-psychotic medication given and then every six months. (AIMS testing will be discontinued if any of the above medication is discontinued). AIMS testing may be done by two employees as indicated

***NOTE: A SCORE OF LESS THAN 4 IS CONSIDERED TO BE NEGATIVE READING.
Revised 01/15**

PHYSICAL EXAMINATION

Examination Procedure:

Either before or after the completing the Examination Procedure observes the resident unobtrusively at rest.

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask resident whether there is anything in his/her mouth (i.e. gum, candy, etc.) and if there is to remove it.
 2. Ask resident about the current condition of his or her teeth. Ask resident if he/she wears dentures. Do teeth or dentures bother the resident now?
 3. Ask resident whether he/she notices any movements in mouth, face, hands or feet. If yes, ask to describe and to what extent they currently bother resident or interfere with his/her activities.
 4. Have resident sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position).
 5. Ask resident to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas).
 6. Ask resident to open mouth (observe tongue at rest in mouth.) Do this twice.
 7. Ask resident to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.
 8. * Ask resident to tap thumb, with each finger, as rapidly as possible for 10 to 15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements).
 9. Flex and extend residents left and right arms (one at a time). Note rigidity and rate on notes.
 10. Ask resident to stand up (observe in profile). Observe all body areas again, hip included.
 11. * Ask resident to extend both arms outstretched in front with palms down (observe trunk, legs and mouth).
 12. * Have resident walk a few paces, turn and walk back to chair (observe hands and gait). Do this twice.
- * Activated Movements
13. The results are to be documented in PCC.

15-MINUTE OBSERVATION – INCREASED SUPERVISION OF RESIDENTS

To assist in ensuring the safety of a resident during an acute change of condition the following procedure shall be implemented.

1. In the event that a resident has a change of condition, depending on the resident's status and nursing judgment, increased supervision/monitoring (15-minute observation) may be instituted.
 - a) Conditions that may warrant the increased supervision include:
 - i. A resident-to-resident altercation.
 - ii. A recent fall.
 - iii. A decline in the resident's cognitive status (e.g. safety awareness), an increase in agitation, an infection such as urinary tract infection, etc.
 - b) Document the increased monitoring.
2. The Licensed nurse assigned to the resident will be responsible for completing the monitoring.
3. 15-minute observations are typically continued for a period of 24 - hours. Changes to this timeframe may occur if the resident is discharged to another facility or if the acute condition subsides and/or continues for a period of greater than 24-hours, at which case the monitoring shall continue.
4. If the situation requires a 1:1 intervention, then this shall supersede the 15-minute observation. (The 15-minute observations should continue if the 1:1 monitor is a volunteer/family member.)
5. Once the observation is finished, the completed form shall be routed to the RN Manager for review and disposition.

Revised 02/15

PRECAUTION – OBSERVATION FORM
(Initial Q 15 minutes – 24 hrs. QD)

PRN PSYCHOTROPIC MEDICATION ASSESSMENT

Procedure:

Prior to the use of a PRN psychotropic, hypnotic, or anti-anxiety medication (when considered for use for behaviors - not related to comfort care and/or air hunger), the licensed nurse will assess the resident for possible causes and/or alternative interventions.

1. The PRN PSYCHOTROPIC/HYPNOTIC/ANTI-ANXIETY MEDICATION ASSESSMENT form will be completed and documented in PCC. Based on the responses, the staff can intervene as appropriate.
2. The completed form will be available in PCC.

Revised 01/15

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V RESIDENT INCIDENT/ACCIDENT REPORTS

INCIDENT /ACCIDENT WORKGROUP

Purpose:

To provide a process to assess and review results of findings and investigation of resident and employee incidences; determine appropriate interventions to decrease/eliminate incidence(s).

Procedure:

1. A multi-disciplinary workgroup (Clinical Team) shall be established to include the Director of Nursing Services, or designee, and representation from Social Services, Activities, Restorative Nursing, and any other individuals the members may deem necessary to assist the workgroup.
2. The Clinical Team shall meet at regularly scheduled intervals to review Incident Report(s).
3. The purpose of the Clinical Team is to further investigate incidences, as necessary, and to determine further interventions and plans to decrease/eliminate the potential for reoccurrence.
4. In the event a resident experiences an incident/accident, a review related of the resident's incident history will be reviewed by the Clinical Team.
5. Trending reports related to incidents and accidents will be generated and analyzed on a monthly basis (more often when deemed appropriate) for presentation in the QA meeting.

Revised 02/18

RESIDENT INCIDENT REPORT

An incident is an unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care (e.g. drug side effects or reactions).

An incident/accident report will be initiated for each of the following events:

- Any type of injury to a resident or staff
- All falls
- Skin tears and bruises
- Resident to resident altercation
- Resident to staff altercation
- Staff to resident altercation
- Any injury to families, staff visitors or volunteers occurring within facility or on the grounds should complete paperwork as designated by HR policy

Procedure:

1. Any individual aware of an incident/accident involving a resident shall report the incident directly to the licensed nurse on the specific resident's unit. If the resident was involved in a fall the CNA is not to assist resident up prior to the LN doing a head to toe assessment and ROM to ensure there is no injury prior to getting the resident off the floor.
2. The Incident Report located in Point Click Care is to be initiated and completed by the attending nurse by end of the shift in which the incident occurred or was reported.
3. Immediate interventions identified and/or taken as the result of the incident shall be implemented and the Care Plan / Kardex will be updated as appropriate. This is to be done by the attending nurse or Charge Nurse.
4. Alert Charting, as appropriate, will be initiated.
5. The DNS or designee will report the incidents to the Clinical Team meeting for multidisciplinary evaluation and/or any further interventions.

Reviewed 02/18

RESIDENT-TO-RESIDENT ALTERCATION

In the event of a resident-to-resident altercation, the following procedure shall be utilized.

1. All residents involved in the altercation should be immediately separated and assessed.
2. Licensed nurse shall conduct an investigation of the alleged incident that includes:
 - a) Completion of the incident report form.
 - b) Interviews with staff and/or witnesses to the incident to obtain specifics about the incident. Obtains written, dated and signed statements as appropriate.
 - c) Notification of the facility Administrator, Director of Nursing Services, RN Manager, and the Director of Social Services.
 - d) Completion of nursing note to include: description of the incident (events leading up to the incident, location of staff prior to, during and after the incident, etc.), steps taken to prevent reoccurrence, assessment of the resident, notification of facility staff and families, and any other information relevant to the incident.
3. Place each resident on alert charting listing what needs to be assessed and/or any new interventions placed.

Revised 01/15

FALL PREVENTION PROGRAM

Policy:

Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls.

Definitions:

A **“fall”** is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.

A **“near miss”**, also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so.

Policy Explanation and Compliance Guidelines:

1. The facility utilizes a standardized risk assessment for determining a resident’s fall risk.
 - a. The risk assessment categorizes residents according to low, moderate, or high risk.
 - b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment.
2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident’s level of fall risk. This assessment will provide a score between 0-38. A score of 0-16 indicates a lower fall risk and a score of 17 and above indicates a higher fall risk. When the resident scores a **17 or above**, the resident will be placed on the facilities High Fall Risk Fall Prevention Protocol.
3. The nurse will indicate on the residents door frame and wheelchair the resident’s fall risk and initiate interventions on the resident’s baseline care plan, in accordance with the resident’s level of risk.
4. The nurse will refer to the facility’s High Risk or Low/Moderate Risk protocols when determining primary interventions.
5. Low/Moderate Risk Protocols: (Fall Risk Score of 0-16):
 - a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to:
 - i. A clear pathway to the bathroom and bedroom doors.
 - ii. Bed is locked and lowered to a level that allows the resident’s feet to be flat on the floor when the resident is sitting on the edge of the bed.
 - iii. Call light and frequently used items are within reach.
 - iv. Adequate lighting.
 - v. Wheelchairs and assistive devices are in good repair.
 - b. Monitor for changes in resident’s cognition, gait, ability to rise/sit, and balance.
 - c. Encourage residents to wear shoes or slippers with non-slip soles when ambulating.
 - d. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating.
 - e. Monitor vital signs in accordance with facility policy.

- f. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes.
-
6. High Risk Protocols(Fall Risk Score of 17 or above):
 - a. The resident will be placed on the facility's Fall Prevention Program.
 - i. Indicate fall risk on care plan.
 - ii. Place Fall Prevention Indicator (*such as star, color coded sticker*) on the name plate to resident's room.
 - iii. Place Fall Prevention Indicator on resident's wheelchair.
 - b. Implement interventions from Low/Moderate Risk Protocols.
 - c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status.
 - d. Provide additional interventions as directed by the resident's assessment, including but not limited to:
 - i. Assistive devices
 - ii. Increased frequency of rounds
 - iii. Sitter, if indicated
 - iv. Medication regimen review
 - v. Low bed
 - vi. Alternate call system access
 - vii. Scheduled ambulation or toileting assistance
 - viii. Family/caregiver or resident education
 - ix. Therapy services referral
 7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program.
 8. The Charge Nurse may place a resident on the Fall Prevention Program out of concern for a resident's safety. The charge nurse will then notify the Fall Prevention Task Force regarding the placement for further evaluation and assessment.
 9. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.
 - a. Interventions will be monitored for effectiveness.
 - b. The plan of care will be revised as needed.
 10. Residents currently on the Fall Prevention Program will be reviewed biannually (June and December) and as needed by the Fall Prevention Task Force for possible reduction of protocol.
 11. When any resident experiences a fall, the facility will:
 - a. Assess the resident.
 - b. Begin a Post Fall/NEURO Assessment form.
 - c. Complete a new fall risk assessment.

- d. Complete an incident report.
- e. Notify physician and family.
- f. Review the resident's care plan and update as indicated.
- g. Document all assessments and actions.
- h. Obtain witness statements in the case of injury.

Reference:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision)*. F689 – Free of Accident Hazards/Supervision/Devices 42 C.F.R. §483.25(d)(1)(2).

10/2019, revised 12/2019

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VI NURSING POSITION DESCRIPTIONS

POSITION DESCRIPTIONS

Position Descriptions for the following classifications can be obtained through the facility's Human Resource Department.

- Director of Nursing Services
- RN Manager
- Staff Development Coordinator
- MDS Coordinator
- Registered Nurse, Senior
- Licensed Practical Nurse
- Certified Nursing Assistant, Senior
- Certified Nursing Assistant
- Physical Occupational Therapy Aide (Restorative Aide)
- Certified Nursing Assistant/ Transportation Aide

IDVS JOB DESCRIPTION –NURSING SERVICES DIRECTOR

Employee's Name:	PCN:
Supervisor: Home Administrator	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
 % = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
1. Management			65%
Manages staff involved in providing resident care in a skilled nursing environment to include licensed and certified nursing staff.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Interprets and applies laws, rules, regulations, policies and procedures	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Hires, trains, and evaluates staff.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Resolves personnel, scheduling, and other conflicts.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Monitors budget expenditures.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Determines inventory and equipment needs.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Determines appropriate staffing levels.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Ensures staff compliance with existing federal and state regulations, standards of nursing practice and facility policies and procedures.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Reviews and evaluates nursing care operations including facility layout, equipment, employee utilization, and work procedures	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Establishes work performance standards.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Program Management			15%
Develops and implements facility procedures.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Identifies program deficiencies and develops appropriate corrective measure	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Directs implementation of programs including goals and objectives and monitor activities in staff development, infection control, RAI, bowel and bladder, incident reporting, nutrition and hydration, etc.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Develops reports related to program and staff activities.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Consultation			15%
Consults with members of interdisciplinary team to determine appropriate resident care interventions.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Chairs and/or is a member of a variety of facility committees related to facility operations and programs.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with families, residents, and facility staff in ensuring quality of resident care.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Perform other duties as assigned			5%
Performs other duties as deemed necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other: Wet floors
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Endurance for frequent sitting, standing, bending, stooping, kneeling, squatting, twisting/turning from waist.
Frequent walking, reaching above shoulder level, moving objects horizontally (left to right) and vertically (up and down) up to 10 lbs., occasionally to 25 lbs.
Frequent handling (holding, grasping, working with hands), fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone. Vision for near/far acuity, depth perception, color vision. Ability to feel size, shape, temperature, texture.

IDVS JOB DESCRIPTION –NURSE, REGISTERED MANAGER

Employee's Name:	PCN:
Supervisor: Director of Nursing Services	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)

% = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
1. Supervision			30%
Supervises licensed nursing staff and certified nursing aides in the delivery of skilled facility nursing care	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Determines appropriate staffing levels and assigns/reassigns as appropriate	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Evaluates and monitors staff performance	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides input into compensation and classification issues.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input checked="" type="checkbox"/> Q <input type="checkbox"/> A	%
Ensures staff compliance with existing State and federal regulations and facility policies and procedures.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Counsels employees regarding work performance/expectations.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Resolves conflicts among staff.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Unit Management			50%
Supervises the activities of a unit within the skilled nursing environment	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Oversees/evaluates staff compliance with facility programs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Monitors/audits and directs timely and appropriate medical record documentation	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Ensures implementation of new programs, policies and procedures	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Participates in and evaluates staff related to quality assurance indicators	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Trains staff/distributes information related to facility operations, nursing practices, laws, and regulations.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with families and medical provider regarding resident care and concern issues.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Encodes RAI documents and ensures compliance with RAI requirements.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Develops/directs the development of individualized resident plans of care and updates as necessary.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Interpersonal Relations/Liaison			15%
Participates in resident care conferences	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with members of the facility interdisciplinary team to determine appropriate course of action related to resident concerns/plan of care.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Serves on various facility/department committees, as requested	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Perform other duties as assigned			5%
Performs other duties as deemed necessary	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other: Wet floors
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from waist.
Limited sitting, reaching above shoulder level.
Pushing/pulling objects on rollers/wheels. Moving objects horizontally (left to right) and vertically (up and down). Frequent lifting up to 10 lbs., occasionally up to 25 lbs. Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care. Frequent handling (holding, grasping, working with hands), fine finger manipulation (pinching, picking, working with fingers).

Senses needed to perform essential functions of the position:

Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone.

Vision for near/far acuity, depth perception, color vision.

Ability to feel size, shape, temperature, texture.

Ability to determine hot/burning equipment.

IDVS JOB DESCRIPTION – MDS COORDINATOR

Employee's Name:	PCN:
Supervisor: Director Of Nursing Services	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)

% = Percentage of total work time devoted to each domain

An employee in this position is responsible for the accurate and timely completion of the RAI process.

Duties and Responsibilities	Essential Function	Frequency	%
1. RAI Process			100%
Establishes calendar to ensure timely completion of the RAI process including MDSs, RAPS, and care plans.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Initiates MDS instrument for other disciplines in timely manner to ensure MDS completion.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Distributes and updates MDS calendar on each of the skilled nursing units.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Communicates time frames to members of interdisciplinary team.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Completes and signs off on MDSs in accordance with established guidelines.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Determines if a significant change in condition has occurred and communicates findings to unit RN Manager and other staff to determine appropriate course of action. Consult with unit RN Managers and other staff, as appropriate, to resolve any discrepancies between information obtained related to residents status/MDS completion and medical record and other available information(e.g. ADL flow sheets, verbal communication with staff, progress notes, MDS focused charting, etc.) as needed.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Reviews identified triggers and completes RAPS to identify care plan interventions.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Communicates care plan needs and revisions to unit RN Managers and other disciplinary staff as appropriate.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Works with Staff Development Coordinator to implement orientation and ongoing staff training on RAI process including gathering information, assessment of residents, and care plan development.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with QA committee to review quality indicators and other factors indicative of care.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assists in the development of systems to identify and improve quality of care.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Perform other duties as assigned			5%
Performs other duties as deemed necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other: Wet floors
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Frequent sitting.
Occasional squatting, twisting/turning from waist.
Limited standing, reaching above shoulder level.
Frequent handling (holding, grasping, working with hands), fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone.

IDVS JOB DESCRIPTION – REGISTERED NURSE, SENIOR

Employee's Name:	PCN:
Supervisor:	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
 % = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
2. Assesses, plans, evaluates, implements and monitors resident health problems and care-related issues.			15 %
<ul style="list-style-type: none"> Handles emergencies independently and makes decisions related to the most appropriate intervention e.g. immediate transport, physician notification, emergency vehicle transport, CPR intervention, etc. 	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
<ul style="list-style-type: none"> Conducts admission assessment and initiates admission documentation. 	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
<ul style="list-style-type: none"> Oversees delivery of care to residents on unit. 	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
<ul style="list-style-type: none"> Ensures staff compliance with governing regulations and facility policies, procedures, and practices. 	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
<ul style="list-style-type: none"> Ensures notification and/or notifies families regarding change in resident status/condition. 	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
<ul style="list-style-type: none"> Completes program assessments such as fall, aims, neurological skin, etc. 	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

• Responds to resident requests/needs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Refers to other parties/providers as appropriate.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Documents resident behaviors/conditions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Notifies medical provider regarding resident condition, as appropriate.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Reports to oncoming shift concerns related to resident status, unfinished business and other pertinent data related to unit activities.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Ensures cares are delivered and documented in appropriate manner and timeframe.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Ensures ordered labs are drawn and transported to lab in a timely manner	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Completes discharge documentation.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Develops and updates individualized plans of care.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Performs duties in compliance with Standards of Nursing practice.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Staff Supervision/Staffing			25 %
• Serves as liaison between nursing units including conflict resolution.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Serves as resource to other RNs and LPNs related to resident health assessments, medications, treatment interventions and care plan updates.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Assigns, directs, instructs, and evaluates licensed nursing staff and certified nursing staff in patient care delivery on assigned shift.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Determines appropriate staffing levels, staff assignments, and staff mix in case of call-ins and 1:1 supervision of unstable residents	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Obtains replacement staff as necessary to accommodate resident and staffing needs.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Coordinates staffing with other floors to maintain minimum staffing levels.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Adjusts employee schedules as necessary to accommodate resident and staffing needs and adjusts staff assignments to provide optimal resident care.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Ensures adequate staffing during resident meals.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

• Evaluates need for medical assistance for employee-related work injuries/illnesses.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Reviews and signs off on resident care flow sheets.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Approves staff overtime as warranted, documents justification.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Documentation			10 %
• Participates in facility quality assurance program by assessing program implementation activities and documents findings of these assessments.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Accurately & completely documents resident assessments & interventions in the medical record.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Documents information r/t <ul style="list-style-type: none"> ○ Focused charting ○ Alert charting ○ Incident reports ○ Monthly summaries 	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Transcribes and notes medical orders.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• May utilize RAI process.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Provides & documents resident treatments	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Medication/Treatment Administration			35 %
• Provides and documents resident treatments.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Dispenses and documents medication administration.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Consults with medical provider and pharmacist regarding medication side-effects, dosages, etc.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
5. Interpersonal Relations			10 %
• Makes rounds with medical provider to elicit/provide resident-specific information.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Works with members of interdisciplinary team to plan problem-specific interventions.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Consults with families to apprise of resident condition and to gather pertinent resident care information.	Yes	<input checked="" type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

6. Other Duties			5%
• Performs other duties as assigned	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other: Wet floors
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

• Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from waist.
• Limited sitting, reaching above shoulder level.
• Pushing/pulling objects on rollers/wheels.
• Moving objects horizontally (left to right) and vertically (up and down).
• Frequent lifting up to 10 lbs., occasionally up to 25 lbs.
• Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care.
• Frequent handling (holding, grasping, working with hands), fine finger manipulation (pinching, picking, working with fingers).
• Senses needed to perform essential functions of the position: <ul style="list-style-type: none"> ○ Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone. ○ Vision for near/far acuity, depth perception, color vision. ○ Ability to feel size, shape, temperature, texture. ○ Ability to determine hot/burning equipment.

IDVS JOB DESCRIPTION – NURSE, LICENSED PRACTICAL

Employee's Name:	PCN:
Supervisor: Unit RN Manager	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)

% = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
Evaluate and monitor resident health problems and care-related issues			25 %
Assesses health status by collecting, reporting, and recording objective data	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Instructs residents/families regarding healthcare related issues	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Ensures direct care staff service delivery	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Notifies families/physician regarding change in resident status	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Completes program assessments such as fall, Aims, neurological, skin, etc.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Responds to resident requests/needs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Documents resident behaviors/conditions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Reports to oncoming shift concerns related to resident status, unfinished business & other pertinent data related to unit activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Updates individualized plans of care & evaluates for effectiveness	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Performs duties in compliance with established standards of nursing practice	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Documentation			25 %
Documents resident assessments & interventions accurately & completely	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Documents information r/t: Focused charting	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Alert charting Incident reports Monthly summaries			
3. Medication/Treatment Administration			35 %
Provides & documents resident treatments	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Dispenses & documents medication administration	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with medical provider & pharmacist regarding medication side-effects, dosages, etc.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Interpersonal relations			10%
Works with members of interdisciplinary team to plan problem-specific interventions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Supervises direct care staff	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
5. Perform other duties as assigned			5%
Performs other duties as deemed necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other: Wet floors
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Frequent standing, stooping, kneeling, squatting, bending, twisting/turning from waist.
Pushing/pulling objects on rollers/wheels.
Frequent walking, reaching above shoulder level, moving objects horizontally (left to right) and vertically (up and down) up to 25 lbs., occasionally to 50 lbs., rarely to 75 lbs.
Frequent handling (holding, grasping, working with hands), fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone. Vision for near/far acuity, depth perception, color vision. Ability to feel size, shape, temperature, texture. Ability to determine hot/burning equipment.

IDVS JOB DESCRIPTION – CERTIFIED NURSING ASSISTANT, SENIOR

Employee's Name:	PCN:
Supervisor: Unit RN Manager	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
% = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
Lead work			10%
Provide resident care training/orientation to certified nursing assistants and other staff as necessary	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assist in ensuring staff compliance with facility policies and procedures and state and federal regulations	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Teach self-help skills to residents	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Audit aide flow sheet/resident behavior documentation/provides input as necessary	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Serve as liaison between direct care staff and licensed nursing staff	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Direct resident health care activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provide input into employee evaluations	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input checked="" type="checkbox"/> A	%
May resolve conflicts between direct care staff	No	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Serve as a trainer in a structured employee orientation program to include preparing and/or presenting certified nursing aide instructional material	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Monitors staff performance R/T resident cares	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Coordinate the integration of new staff into unit activities/schedules	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consult with interdisciplinary staff to develop/revise training materials.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Patient Care			75 %
Answer call lights to determine resident needs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Obtain and records vital signs.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provide personal hygiene care including pericare and bathing activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assist residents with activities of daily living, as necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Lift, transfer, reposition, and escort residents	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assist residents with ambulation and other body movements	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Feed residents as required	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Responsible for providing direct resident care on a hall/zone	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provide input into and implement individualized resident care in accordance with standards of practice and resident plan of care.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Report changes in resident condition to licensed nursing staff or other facility staff as appropriate	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Maintain a safe and sanitary resident-care environment	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consult with other staff, as needed, to determine appropriate interventions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Documentation			10 %
Observe, report, and record resident activities and behaviors	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Audit aide documentation, provide feedback as appropriate	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Miscellaneous			5 %
Assist in determining appropriate stocking levels for unit supplies, restock/reorder as necessary.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provide input into facility operations, policies, and procedures	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Participate on facility committees when appropriate.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Transport residents to and from facility, as needed.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
7. Perform other duties as assigned			
Perform other duties as deemed necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other:
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Endurance (requiring cardiovascular fitness) for frequent standing, walking, bending, stooping, pushing/pulling objects on rollers/wheels, moving objects horizontally (left to right) and vertically (up and down) frequently up to 20lbs. Occasionally up to 50lbs, rarely up to 75lbs.
Occasional sitting, kneeling, squatting, twisting/turning from waist, reaching above shoulder level.
Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care.
Frequent handling (holding grasping, working with hands) and fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Ability to hear and talk in quiet/noisy surroundings and over the phone. Vision for near/far acuity, depth perception, color vision. Ability to feel size, shape, temperature, texture. Ability to determine hot/burning equipment.

IDVS JOB DESCRIPTION – CERTIFIED NURSING ASSISTANT

Employee's Name:	PCN:
Supervisor:	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
 % = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
Patient Care			80 %
Answers call lights to determine resident needs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Obtains and records vital signs.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides personal hygiene care including pericare and bathing activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assists residents with activities of daily living, as necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Lifts, transfers, repositions, and escorts residents	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assists residents with ambulation and other body movements	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Feeds residents as required	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Implements individualized resident care in accordance with standards of practice and resident plan of care	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Reports changes in resident condition to licensed nursing staff or other facility staff as appropriate	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Maintains a safe and sanitary resident-care environment	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with other staff, as needed, to determine appropriate interventions and completes tasks as delegated	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Documentation			15 %
Observes, reports, and records resident activities and behaviors	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

3. Miscellaneous			5 %
Instructs residents regarding safe transferring skills and other activities of daily living.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Orients new employees, students and volunteers.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides input into facility operations, policies, and procedures	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Participates on facility committees, as appropriate.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Transports residents to and from facility, as needed.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Bathing (Option)			
Notifies assigned staff and retrieves residents scheduled for bathing/showering	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Ensures bathing process does not interfere with resident activities, therapy, meals, or rest periods	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Bathes/showers residents in accordance with standards of care and resident preferences	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Shampoos hair, shaves facial hair, trim nails on non-diabetic residents, and provides other personal cares as appropriate	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Develops and/or provides input into the development of the unit's bathing schedule	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Maintains current resident bathing schedule	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Maintain daily bathing record and skin assessment information	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Documents bathing activities on each resident's flow sheet, including rational for refusal, as necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Notifies nurse assigned to resident immediately upon discovery of skin wounds, bruises, scraps or skin tears, rashes or other problems	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Notifies nurse regarding unfinished baths, residents in need of PM or weekend bath, etc.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
5. Perform other duties as assigned			5%
Performs other duties as assigned/delegated	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other:

<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:
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Physical Requirements

Endurance (requiring cardiovascular fitness) for frequent standing, walking, bending, stooping, pushing/pulling objects on rollers/wheels, moving objects horizontally (left to right) and vertically (up and down) frequently up to 20lbs. Occasionally up to 50lbs, rarely up to 75lbs.
Occasional sitting, kneeling, squatting, twisting/turning from waist, reaching above shoulder level.
Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care.
Frequent handling (holding grasping, working with hands) and fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Frequent need to hear and talk in quiet/noisy surroundings and over the phone. Vision for near/far acuity, depth perception, color vision. Touch for feeling (size, shape, temperature, texture by finger receptors). Smell to determine hot/burning equipment.

IDVS Job Description – Physical Occupational Therapy Aide (RESTORATIVE AIDE)

Employee's Name:	PCN:
Supervisor: Rehab Nurse	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency	%
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
 % = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
Therapy			75 %
Implements therapeutic plans of care to include ambulation and range of motion.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assists residents in activities to promote self-care.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Instructs/encourages resident participation in activities/exercises	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Prepares equipment and ensures availability of supplies	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Assists in the preparation of residents receiving treatment	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Schedules residents for therapy	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Serves as a liaison between therapy and facility staff	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides input into individualized resident care planning	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Trains/orients staff in safe transferring techniques and other related therapy activities.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Observes, records, and reports resident progress with therapy activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Consults with nursing staff as appropriate regarding resident status/change	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides input into MDS documentation including balance and gain	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Position Devices			10 %

Consults with physical therapist/Occupational therapist assesses resident for current and potential use of positioning devices.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Communicates resident positioning needs to nursing staff and other interdisciplinary team members, as appropriate.	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Updates resident care plans and ADL flow sheets to reflect positioning device interventions.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
In-services staff regarding the application and use of positioning devices.	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Patient Cares			5%
Obtains and records vital signs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Provides personnel cares related to activities of daily living.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Documents resident activities/behaviors	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
4. Miscellaneous			10%
Participates on facility committees, if need.	No	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Transports residents to and from Facility, as necessary.	No	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
5. Perform other duties as assigned			
Performs other duties as deemed necessary	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

Working Environment. The position involves risk of exposure to:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other:
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

Endurance (requiring cardiovascular fitness) for frequent standing, walking, bending, stooping, pushing/pulling objects on rollers/wheels, moving objects horizontally (left to right) and vertically (up and down) frequently up to 20lbs. Occasionally up to 50lbs, rarely up to 75lbs.
Occasional sitting, kneeling, squatting, twisting/turning from waist, reaching above shoulder level.
Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care.
Frequent handling (holding grasping, working with hands) and fine finger manipulation (pinching, picking, working with fingers).
Senses needed to perform essential functions of the position: Ability to hear and talk in quiet/noisy surroundings and over the phone. Vision for near/far acuity, depth perception, color vision. Ability to feel size, shape, temperature, texture. Ability to determine hot/burning equipment.

IDVS JOB DESCRIPTION – CERTIFIED NURSING ASSISTANT/TRANSPORTATION AIDE

Employee's Name:	PCN:
Supervisor:	Date:

I have received a copy of this job description and understand the duties and essential functions as described. I am able to perform the essential functions of the position, **without or without** reasonable accommodation. (See HR for reasonable accommodation information)

Employee's Signature:	Date:
Supervisor's Signature:	Date:

Duties and Responsibilities	Frequency %
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F = Frequency (D-Daily; W-Weekly; M-Monthly; Q-Quarterly; A-Annually)
 % = Percentage of total work time devoted to each domain

Duties and Responsibilities	Essential Function	Frequency	%
3. Patient Care			25 %
• Answers call lights to determine resident needs	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Obtains and records vital signs.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Provides personal hygiene care including peri-care and bathing activities	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Assists residents with activities of daily living, as necessary	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Lifts, transfers, repositions, and escorts residents	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Assists residents with ambulation and other body movements	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Feeds residents as required	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Implements individualized resident care in accordance with standards of practice and resident plan of care	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Reports changes in resident condition to licensed nursing staff or other facility staff as appropriate	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Maintains a safe and sanitary resident-care environment	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

• Consults with other staff, as needed, to determine appropriate interventions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
2. Documentation			15 %
• Observes, reports, and records resident activities and behaviors	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
3. Miscellaneous			5 %
• Instructs residents regarding safe transferring skills and other activities of daily living	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• May orient new employees, students and volunteers	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Provides input into facility operations, policies, and procedures	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• May participate on facility committees	Yes	<input type="checkbox"/> D <input type="checkbox"/> W <input checked="" type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Maintains a professional appearance & and report with all medical offices/facilities in the community	Yes	<input type="checkbox"/> D <input checked="" type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Acts as a liaison between resident's family Member & the facility of the appt.			
4. Transportation Aide			50%
• Coordinates with Admission Coordinator for new admit & re-admit transports	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Coordinates with Nursing unit clerks for daily changes or appts added to schedule	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Screens transport calendar daily for conflicts & notifies unit clerk for amendments/changes when needed	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Keeps Restorative Mgr. informed of situations as they arise	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Signs for Residential Care medications at VAMC & delivers meds to 2-East	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Ensures that each resident is clean, dressed appropriately & toileted prior to their appt.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Ensures that residents have had their scheduled medications prior to leaving for their appts.	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
Ensure proper outer clothing for the weather Conditions	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• All residents have equipment needed for transport: foot pedals on w/c, walker, cane, O2 tank is full & serviceable. Extra change of clothing, incontinent products & wipes are available if needed	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%
• Transport Aide has all appropriate documentation/paperwork needed for this	Yes	<input checked="" type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Q <input type="checkbox"/> A	%

resident's appt. & returns all paperwork to unit clerk when appt is completed.												
Ensures that all residents are accompanied by A staff/family member to appts. as needed	Yes	X-	D	W	M	Q	A					
4. Perform other duties as assigned							5%					
• Performs other duties as deemed necessary	Yes	<input type="checkbox"/>	D	<input type="checkbox"/>	W	<input type="checkbox"/>	M	<input type="checkbox"/>	Q	<input type="checkbox"/>	A	%

Working Environment

The position involves risk of exposure of:

<input checked="" type="checkbox"/> Blood and bodily fluids	<input checked="" type="checkbox"/> Latex	<input checked="" type="checkbox"/> Odors, chemicals
<input checked="" type="checkbox"/> Disease	<input checked="" type="checkbox"/> Hazardous Drugs	<input type="checkbox"/> Other:
<input checked="" type="checkbox"/> TB (to require mask)	<input checked="" type="checkbox"/> Mechanical/Electrical	<input type="checkbox"/> Other:

Physical Requirements

<ul style="list-style-type: none"> • Endurance (requiring cardiovascular fitness) for frequent standing, walking, bending, stooping, pushing/pulling objects on rollers/wheels, moving objects horizontally (left to right) and vertically (up and down) frequently up to 20lbs. Occasionally up to 50lbs, rarely up to 75lbs.
<ul style="list-style-type: none"> • Occasional sitting, kneeling, squatting, twisting/turning from waist, reaching above shoulder level.
<ul style="list-style-type: none"> • Ability to maintain a stable posture and gait with hands free to perform anticipated (or routine) and emergent patient care.
<ul style="list-style-type: none"> • Frequent handling (holding grasping, working with hands) and fine finger manipulation (pinching, picking, working with fingers).
<ul style="list-style-type: none"> • Senses needed to perform essential functions of the position: <ul style="list-style-type: none"> ○ Frequent need to hear and talk in quiet/noisy surroundings and over the phone. ○ Vision for near/far acuity, depth perception, color vision. ○ Touch for feeling (size, shape, temperature, texture by finger receptors). ○ Smell to determine hot/burning equipment.

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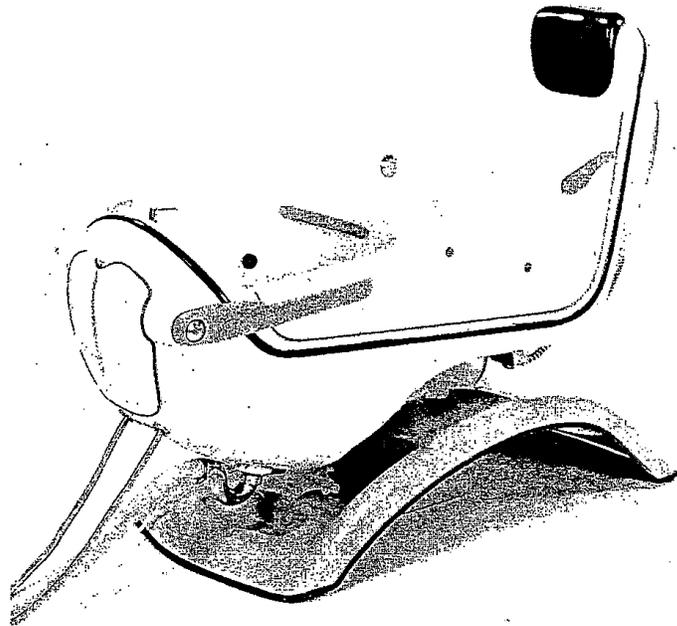
VII CARES

ARJO-PARKER TUB

* See attached Operating and Daily Maintenance Instructions for the Arjo Parker Tub System



Parker Bath



Operating and Daily Maintenance Instructions

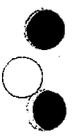


04.AL.00/1 US, CA



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Labels

MODEL: AL XXXX-XX

 Max 190 kg
419 lb.  120 mm

Model Type: Parker Bath Electric
Input Voltage: 120V - 60Hz
Input Current: 9.2 Amps Max.
Degree of Protection: Type B Applied part
Type of Protection: CLASS I
Duty Cycle: 1 min ON / 9 min OFF

HOSPITAL GRADE - Ground reliability can only be achieved when connected to an equivalent receptacle marked 'Hospital Only' or 'Hospital Grade'

 MEDICAL ELECTRICAL EQUIPMENT
UL2601-1 and
CAN/CSA-C22.2 No.601.1
E3N.M 

 Read the operating instructions before use
Merci de prendre connaissance de la notice d'utilisation
Lesen Sie bitte die Bedienungsanleitung durch

8418531

Example of Data Labels

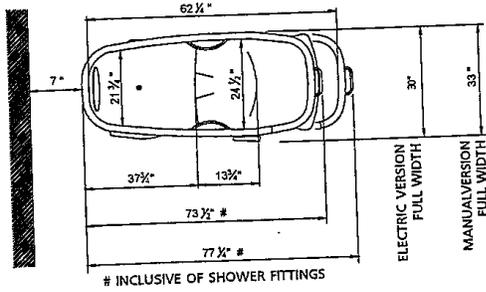
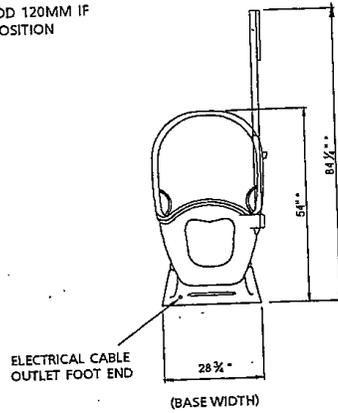
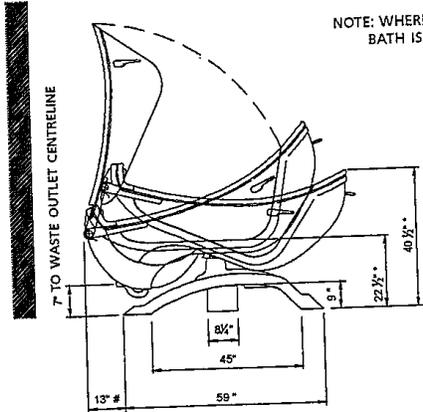
 Medical Electrical Equipment
Classified by Underwriters Laboratories
Inc. with respect to electric shock, fire,
mechanical hazards only in accordance
with UL 2601-1 and CAN/CSA C22.2 No.
601.1

 Type B Applied Part

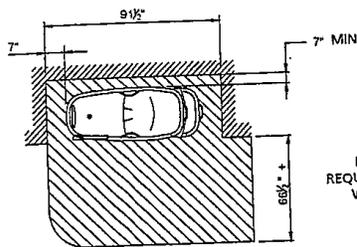
 Attention, consult accompanying
documents

Typical Bathroom Layout

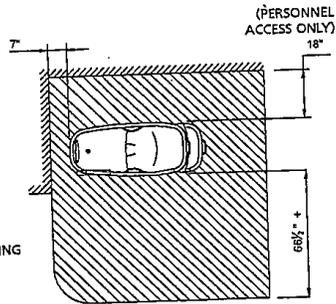
NOTE: WHERE SHOWN * ADD 120MM IF BATH IS IN HIGHEST POSITION



CONVERSION
 Inches to Millimetres:
 Number of Inches x 25.4 = mm



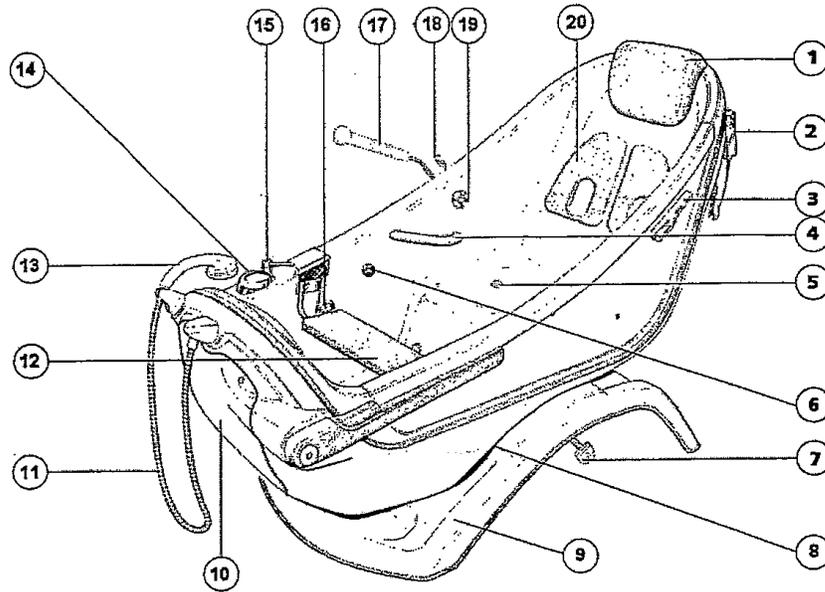
ALCOVE / CORNER POSITION



PENINSULAR POSITION

Ref: TD0011-A

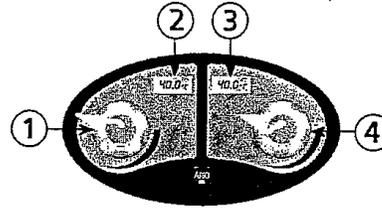
Part Designation



ITEM	DESCRIPTION	COMMENTS
1	Head Cushion	
2	Hand Control	<i>Electric model only</i>
3	Door Handle	
4	Inner Grab Handle	
5	Air Spa Jet	
6	Disinfection Connection	
7	Foot Pedal	<i>Manual model only - Pump up and down to raise bath, press and hold to lower.</i>
8	Air Spa Diverter	Located under the bath and is blue in colour
9	Base Cover	
10	Front Access Panel	
11	Shower Hose	
12	Leg Rest	
13	Shower Head	
14	Spout	
15	Soap Dispenser	Push down on top of dispenser to operate
16	Pop Up Waste	Rotate clockwise to open, anti clockwise to close (integral overflow)
17	Pump Handle	<i>Manual model only - pump up and down to recline bath</i>
18	Relief Valve	<i>Manual model only - turn anti clockwise to return bath to upright position</i>
19	Air Spa Button	On / Off
20	Back Cushions	

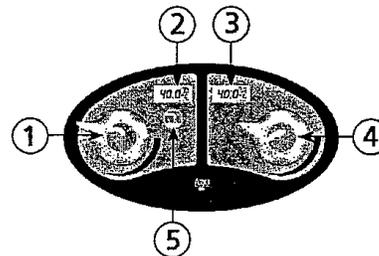
D08 Thermostatic Water Panel

1. To set the water temperature, rotate the bath fill control (1) anti clockwise until the desired temperature is indicated on the digital display (2).
2. Fill the footwell. Top up as necessary.
3. To operate the shower, rotate the shower control (4) anti clockwise until the desired temperature is indicated on the digital display (3).



D08 Thermostatic Water Panel with Autofill

1. To set the water temperature, rotate the bath fill control (1) anti clockwise to the approximate required temperature using the mixing gradient on the panel as a guide.
2. Press button (5) once to start Autofill - indicator light will illuminate. Check temperature on display panel (2) and adjust if necessary. Press again to stop filling at any time.
3. Rotate the bath fill control (1) to adjust the temperature and close the pop up waste. Autofill will stop when fill level is reached. To top up, press button once. The bath will fill for 45 seconds. Do not leave unattended whilst patient is in the bath.
ON FIRST TIME USE, PLEASE TIME AND CHECK THAT BATH FILLS AS DESCRIBED AND THE 45 SECOND TOP UP FUNCTIONS CORRECTLY.
4. To operate the shower, rotate the shower control (4) anti clockwise until the desired temperature is reached (3).
5. At the end of the bathing cycle, turn off the bath fill by rotating fully clockwise.



Always check the water temperature by hand



Maintenance

Only suitably qualified personnel should be consulted for any plumbing and electrical problems or faults. If in doubt, please contact Arjo's Service Department or the local dealer for your country.

The following maintenance schedule is recommended to ensure that warranty is not invalidated.

AFTER EACH USE

Clean the bath using Arjo's disinfectant/cleaner, which can be supplied on request. **DO NOT** use abrasive bleach based cleaners, as these will cause damage to the surface of the bath. Use of such cleaners will automatically invalidate your warranty against surface damage.

ANNUALLY

A full service and safety check should be performed by our fully trained service engineers. For further information about this service, please contact Arjo's Service Department.

THERMOSTATIC MIXERS

It is recommended that all thermostatic mixers undergo a safety check at least once a year. Please contact Arjo's Service Department for further information.

DO8 THERMOSTATIC WATER PANEL

In all cases where users are deemed at risk, irrespective of supply or usage conditions or the evidence of performance checks, the cartridge assembly should be replaced at intervals of no more than 3 years.

Check blend temperature every six months against a known datum (refer to set up procedure), by isolating cold water supply.

Ensure any in-line or integral check valves, strainers are clean and in good working order.

CAUTION

Ensure lubricants used during servicing meet local codes and approvals. **Do not** use mineral oil based lubricant types as rapid deterioration of seals may occur.

TEMPERATURE GAUGE BATTERY REPLACEMENT

Remove the front access panel. Remove the battery and replace with a similar type (AAA). Check the temperature probes are correctly in position. Refit the front access panel and secure.



When fitted, air spa units are supplied with an internal pipe cleaning facility, which can only be used with the optional wall mounted Disinfection System. For full details on cleaning the air spa units, refer to operational Manual for the Disinfection System.



Technical Specification

MEASUREMENTS, VOLUME AND WEIGHTS	ELECTRIC	MANUAL
Bath length (upright position)	73½ inches	73½ inches
Bath length (reclined position)	77 inches	77 inches
Bath width	30 inches	34 inches
Total weight	265 lbs	258 lbs
Water consumption*	24 US gallons	24 US gallons
Filling time at 43.5 PSI dynamic pressure	1.6 minutes	1.6 minutes
Emptying time (free discharge) *	2.2 minutes	2.2 minutes
Transfer height: lowest position	22½ inches	22½ inches
Transfer height: highest position	27¼ inches	27¼ inches
Stroke range	4¾ inches	4¾ inches
Lifting capacity (full load)	419 lbs	419 lbs
Raising time (full load) approximately	17 seconds	12 seconds
Lowering time (full load) approximately	10 seconds	12 seconds
Maximum floor load	226lbs/foot pad 72lbs/inch ²	226lbs/foot pad 72lbs/inch ²
Minimum drainage facility	15.8 US galls/min	15.8 US galls/min

* Prefilled footwell volume

ENVIRONMENTAL LIMITATIONS (ELECTRIC AND MANUAL)

Maximum ambient temperature	+86°F
Maximum relative humidity (non-condensing)	65%

MEASUREMENTS, VOLUME AND WEIGHTS	ELECTRIC	MANUAL
Tub length (upright position)	1865 mm	1865 mm
Tub length (reclined position)	1960 mm	1960 mm
Tub width	760 mm	840 mm
Total weight	120 kgs	117 kgs
Water consumption*	90 Litres	90 Litres
Filling time at 3.0 Bar (43.5 PSI) dynamic pressure	1.5 minutes	1.5 minutes
Emptying time - (free discharge) *	2.2 minutes	2.2 minutes
Transfer height: lowest position	570 mm	570 mm
Transfer height: highest position	690 mm	690 mm
Stroke range	120 mm	120 mm
Lifting capacity (full load)	190 kgs	190 kgs
Raising time (full load) approximately	17 seconds	12 seconds
Lowering time (full load) approximately	10 seconds	12 seconds
Maximum floor load	1010N/foot pad 0.52N/mm ²	1000 N/foot pad 0.52N/mm ²
Minimum drainage facility	60 L/min	60 L/min

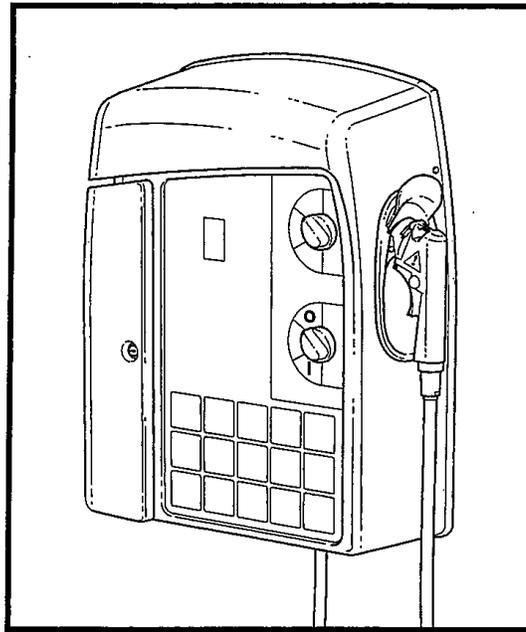
* prefilled footwell volume

ENVIRONMENTAL LIMITATIONS (ELECTRIC AND MANUAL)

Maximum ambient temperature	+30°C
Maximum relative humidity (non-condensing)	65%



MultiClean



Operating and Product Care Instructions



Foreword

Thank you for purchasing ARJO Equipment.

We are dedicated to serving your needs and providing the best products available, along with training, that will bring your staff maximum benefit from every ARJO product.

Please contact us if you have any questions about the operation or maintenance of your ARJO system.

Information in this manual is crucial to the proper operation and maintenance of the equipment, will help protect your investment and ensure that the equipment performs to your satisfaction. Some of the information in this manual is important for your safety, and must be read and understood to help prevent possible injury.

If there is anything in the manual that is confusing or difficult to understand, please call the Service Department for clarification before installing or using this equipment.

ARJO strongly advise and warn that only ARJO designed parts, which are designed for the purpose, should be used on equipment and other appliances supplied by ARJO to avoid injuries attributable to the use of inadequate parts.

Service and Support

A service routine has to be carried out every year by ARJO authorised service personnel to ensure the safety and operating procedures of your product. If you require further information, please contact your local ARJO representative who can offer comprehensive support and service programs to maximise the long term safety, reliability and value of the product.

Symbols definition in this manual:



Safety Warning. Failure to understand and obey this warning may result in injury to you or to others.

NOTE!

This is important information for the correct use of this system or equipment



Protective clothing and eyewear is recommended.

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 AUSTR
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 Föhren
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 Tel: 05-
 Faxnr: ()
 BELGI
 Arjo Hi
 Terness
 B-2160
 Tel: 03-
 Fax: 03-
 E-mail:
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 CANA
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 1575 S
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 ASSI
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 Arjo H
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 Tel: 4-
 Fax: 4-
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 Arjo E
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 Tel: 2-
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Safety Instructions

This equipment must be used in accordance with these safety instructions.

Anyone using this equipment must also have read and understood the instructions in this booklet.

If there is anything you are not sure about, ask your supplier.

If modifications are made to the equipment without the express acknowledgement of ARJO, or if the product is not checked and maintained according to the care and maintenance instructions in this manual, the product liability will be invalidated.

Intended Use:

This equipment is intended for use in hospital or nursing care homes as a disinfection/cleaning system for bathing and showering equipment. It should only be used under the supervision of trained skilled staff in accordance with the instructions outlined in the operating and daily maintenance instructions. All other uses must be avoided.

The equipment must only be used for the purposes stated above, and must be installed according to the recommendations given in this manual.

The normal useful life of this equipment, unless otherwise stated, is ten (10) years, subject to required preventive maintenance as specified.



Always make sure that:

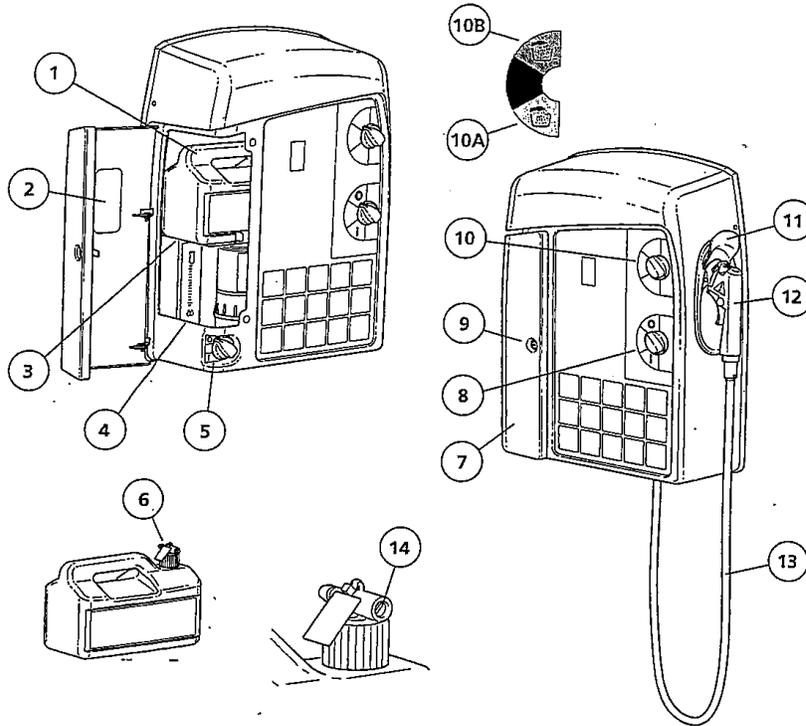
- The equipment is handled by trained staff
- Your skin and eyes are protected against concentrated disinfectant/cleaner. Carefully follow the instructions for the disinfectant cleaner.
- Avoid long term inhalation of neat disinfectant liquid.
- If disinfectant liquid comes into contact with skin wash the affected area with soap and water.
- If disinfectant liquid comes into contact with the eyes, rinse eyes immediately with copious amounts of water for at least 10 minutes. Seek medical advice as necessary.
- If disinfectant liquid is ingested, DO NOT induce vomiting. Give milk or water to drink. Seek medical advice as necessary.
- Always ensure that the shower head is pointing away from you at all times.
- Never use the MultiClean or disinfectant on people.

NOTE!

Modifications made to the equipment without the express acknowledgement of ARJO will invalidate supplier's product liability.



Part Designation



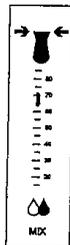
ITEM	DESCRIPTION	COMMENTS
1	Disinfectant Bottle	3 Litre (101 fl.oz)
2	Viewing Window	
3	Disinfectant Storage Tray	
4	Flowmeter	
5	Isolation Valve (shut off) Control	I = Open O = Closed
6	Bottle Connector	
7	Access door	
8	ON/OFF Control	I = On O = Off
9	Door Lock	
10	Function Selecton Control	A (Yellow) = Disinfect B (Blue) = Rinse
11	Spray Handle Holder	
12	Spray Handle	
13	Shower Hose 2 Metre (79")	3 Metres (118") available
14	Adjustment Screw	To adjust concentration setting

Operating Instructions

Preparation - Setting the Disinfectant Concentration

DISINFECTANT / CLEANER	FLOWMETER SETTING	MIX RATIO	KILL STRENGTH
ArjoClean EU	65-70	16 ml/1Ltr -	1440 ppm
CenKleen IV USA	35-40	60ml/4Ltr 2fl.oz/Gal (US)	873 ppm
ARJO Disinfectant Cleaner IV CA	35-40	32ml/4Ltr 1fl.oz/Gal (US)	868 ppm
Arjo General Purpose Disinfectant CA	35-40	32ml/4Ltr 1fl.oz/Gal (US)	868 ppm
Arjo All Purpose Disinfectant CA	75-80	32ml/4Ltr 1fl.oz/Gal (US)	614 ppm

- 1 Unlock and open the access door (7) and with the bottle connector (6) secured in place, place a bottle of Arjo disinfectant/cleaner (1) onto the disinfectant storage tray (3).
- 2 Ensure that all services are connected to the MultiClean.
- 3 Open the water supply by turning the isolation valve control (5) to the open position.
- 4 Switch the unit on by turning the ON/OFF control (8) to the ON position.
- 5 Remove the disinfectant spray handle (12) from its holder (11) and direct it against the bottom of the bath or an appropriate drainage point, but always away from the user.
- 6 Turn the function selection control (10) to the disinfect setting (10A).
- 7 Press the trigger on the spray handle.
- 8 Check the liquid value on the flowmeter setting (4) so it is in accordance with the setting range in the table above. If necessary, adjust using the adjustment screw (14) on the bottle connector - clockwise to decrease the value, anti clockwise to increase.



e.g. ArjoClean setting 65-70

- 9 Replace the spray handle, close and lock the access door.
- 10 Switch the unit off by turning the ON/OFF control (8) to the OFF position.

Contact Times

The contact time of the disinfectant can be varied depending on the specific environmental circumstances. ARJO recommend that 10 minutes is the optimum contact time to insure best disinfection. This should be practised at the start and end of the day and after each time the bath or shower is used.

However, it may be appropriate for the contact time to be a minimum of 2 minutes where risk of cross infection is considered low.

Disinfectant Replenishment



Disinfectant is harmful through contact or ingestion. Always use protective clothing and eyewear when handling. Avoid direct contact with skin or eyes. Should disinfectant come into contact with the skin or eyes, rinse with copious amounts of water. If skin or eyes become irritated, consult a doctor.

Use only Arjo disinfectant/cleaners.

If you require further information regarding the Arjo disinfectant/cleaners please contact your local service department.

- 1 Ensure the ON/OFF control (8) is switched to the OFF position.
- 2 Using the key provided (9), open the access door (7).
- 3 Partially withdraw the empty bottle from the disinfectant storage tray (3). Unscrew and remove the bottle connector (6).
- 4 Remove the empty bottle and use the lid from the new bottle to seal. Dispose of the used container safely.
- 5 Refit and tighten the bottle connector. Place the new bottle of Arjo disinfectant/cleaner (1) onto the disinfectant storage tray and close and lock the door.
- 6 Wipe any residual disinfectant from the unit.
- 7 Switch the unit on by turning the ON/OFF (8) control to the ON position.
- 8 Remove the disinfectant spray handle (12) from its holder (11) and direct it against the bottom of the bath or an appropriate drainage point.
- 9 Turn the function selection control (10) to the disinfectant setting.
- 10 Press the trigger on the spray handle.
- 11 Check the liquid value on the flowmeter (4) to ensure that it is in accordance with the setting range in the recommendations. If necessary, adjust the adjustment screw (14) on the bottle connector - clockwise to decrease the value, anti clockwise to increase.
- 12 Replace the spray handle.
- 13 Switch the unit off by turning the ON/OFF control (8) to the closed position.

Done by
AOK STAFF

Preventive Maintenance Schedule

The daily maintenance and customer obligations shall be carried out in accordance with the schedule below.



Mandatory maintenance shall be carried out by fully trained, qualified service personnel using the correct tools and with knowledge of the maintenance procedures. Failure to meet these requirements could result in personal injuries and/or unsafe equipment.

The equipment is a subject for wear and tear and the following maintenance instructions must be performed when specified to ensure that the equipment remains within its original manufacturing specification.

Cleaning

Clean the MultiClean with a soft cloth soaked with diluted disinfectant/cleaner dispensed from the handset. Alternatively, use a soap or synthetic detergent and water soaked cloth ensuring that the unit is dried after cleaning.

DO NOT use abrasive bleach or solvent based cleaners, as these will cause damage to the plastic surfaces. Use of such cleaners will automatically invalidate your warranty against surface damage.

Action / check	Daily	Weekly	Every 6 Months	Every 12 Months	Every 24 Months	
Customer Obligation X Cleaning	X					
Examine for damage	X					
Customer Obligation X Check flow meter setting	X					⚠
Examine for leaks		X				⚠
ARJO authorized service (X) Apply lubricant to door hinge			(X)			
Check all hoses for leaks				(X)		
Check/clean flow regulator				(X)		⚠
Clean spray handle				(X)		
Check isolation valve operation				(X)		
Check internal fittings are secure				(X)		⚠
Clean and inspect inline strainer				(X)		⚠
Replace washers					(X)	⚠
Replace solenoid valve					(X)	⚠

Technical Specification

MULTICLEAN - PUMPED VERSION		
MEASUREMENTS, VOLUME AND WEIGHTS	METRIC	IMPERIAL
Unit height	578 mm	22 3/4 inches
Unit width	484 mm	19 inches
Unit depth	200 mm	8 inches
Total weight (excluding ArjoClean Disinfectant/Cleaner)	13 kg	29 lbs
Total weight (including ArjoClean Disinfectant/Cleaner)	16 kg	35 1/2 lbs
CONNECTION DEMANDS		
Inlet Coupling (Cold Water)	15 mm	1/2 inches
Overflow	19 mm	3/4 inches
Minimum Flow Rate - Inlet	6 Ltr/Min	1,6 US Gal/Min
Minimum Flow Rate -Outlet	5 Ltr/Min	1,3 US Gal/Min
Minimum Dynamic Pressure	0,3 Bar	2,9 PSI
Maximum Static Pressure	6 Bar	87 PSI
ENVIRONMENTAL LIMITATIONS		
Maximum ambient temperature	+40°C	104°F
Maximum relative humidity (non-condensing)	80 %	80 %
Disinfectant/Cleaner Storage within unit	0°C Min - 30°C Max	32°F Min - 86°F Max

MULTICLEAN - STANDARD VERSION		
MEASUREMENTS, VOLUME AND WEIGHTS	METRIC	IMPERIAL
Unit height	578 mm	22 3/4 inches
Unit width	484 mm	19 inches
Unit depth	200 mm	8 inches
Total weight (excluding ArjoClean Disinfectant/Cleaner)	11 kg	24 1/2 lbs
Total weight (including ArjoClean Disinfectant/Cleaner)	14 kg	31 lbs
CONNECTION DEMANDS		
Inlet Coupling (Cold Water)	15 mm	1/2 inch
Overflow	15 mm	1/2 inch
Minimum Flow Rate - Inlet	6 Ltr/Min	1,6 US Gal/Min
Minimum Flow Rate -Outlet	5 Ltr/Min	1,3 US Gal/Min
Minimum Dynamic Pressure	2 Bar	29 PSI
Maximum Static Pressure	6 Bar	87 PSI
ENVIRONMENTAL LIMITATIONS		
Maximum ambient temperature	+40°C	104°F
Maximum relative humidity (non-condensing)	80 %	80 %
Disinfectant/Cleaner Storage within unit	0°C Min - 30°C Max	32°F Min - 86°F Max

ALCOHOL OR TEPID SPONGE BATH

When a resident has an elevated temperature, a tepid or alcohol sponge bath may be requested. The following steps will be followed:

1. Explain procedure to resident.
2. Fold top bedding down to foot of bed.
3. Place bath blanket under resident.
4. Place bath blanket over resident.
5. Check vital signs, condition.
6. Offer cool fluids.
7. Place wash cloths in prescribed solution.

Place:

- a) Forehead
- b) Axillas
- c) Abdomen
- d) Groin areas

Replace cool washcloths for approximately 20 minutes.

8. After 30 minutes, recheck vitals, record.
9. Report to charge nurse for further instructions.

BED MAKING - AMBULATORY BED

Basic bed unit consists of bed, mattress with cover or pad, bottom sheet, top sheet, blanket spread and pillow. Beds are cleaned and prepared for occupancy by housekeeping staff following discharge of patient. Water mattresses or alternating air mattresses may be used at discretion of nursing supervisor or physician.

Procedure	Points of Emphasis
1. Wash hands.	
2. Lower backrest to flat position	Raise bed to work level.
3. Move bedside table and chair	Will allow ample work area.
4. Place pillow and linen on chair.	Arrange in order of use
5. Remove linen from bed one article at a time.	Fold reusable linen and place on chair; discard other linen into bag.
6. Push mattress to head of bed.	
7. Place sheet lengthwise on mattress, foot and even with mattress edge.	Place center fold at center of bed.
Tuck in sheet at top and make square corner.	
9. Place second sheet lengthwise on head end of bed even with mattress edge.	If only one clean sheet is being used, it is preferable to use it as top sheet.
10. Tuck in sheet at bottom and make square corner.	
11. Place spread lengthwise on bed.	Arrange top edge about ten inches from head of bed.
12. Tuck in spread at bottom and make mitered corner.	
13. Go to other side of bed.	Fold back bedding to bottom sheet.
14. Repeat steps 9 through 13.	Tighten linen as much as possible, but allow for foot room.
15. Turn edge of top sheet over spread.	
16. Fan-fold top bedding to lower end of bed.	
17. Slip pillow into pillow case.	Push corners of pillow into corners of pillow case.
18. Place pillows on bed.	Place seamed side away from resident.
19. Replace bedside table and chair in proper position.	
20. Lock wheels of bed.	To prevent accidents.
21. Attach bell cord to sheet with clip.	Pins are not used, as they may damage linen and mattress cover.
22. Leave bed in low position at all times.	

RESIDENT CARES GUIDELINES

Procedure:

1. The AM, PM, and NOC cares provided to residents in this facility will be documented on the POC (Aide Flow Sheet if POC not available).
2. In the event a resident either refuses or resists any of the cares offered then the aide assigned the resident shall indicate this refusal or resist. The information as to the specific care refused or resisted is to be documented in POC (or the reverse side of the flow sheet).
3. The resident's refusal or resistance to care(s) shall be communicated per above and to the licensed nurse assigned the resident at the time of occurrence. The licensed nurse shall assess situation and determine appropriate course for further interventions and document actions/findings in the nurse progress note section of the medical record.

Protocol:

The following are a list of cares that typically are provided to the residents of the facility on each of the shifts. (This list is not inclusive or exclusive of cares provided individual residents.)

AM Cares:

- Dressing/assisting resident in appropriate clothing
- Providing oral hygiene
- Washing face & hands
- Combing/brushing hair
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room and assure that there is no personal belongings in pockets or tissues with clothing (laundry services will do an additional "pat down" of clothing prior to washing)
- Passing Water/Ice
- Tidying room
- Applying appropriate support devices as ordered/care planned
- Placing call light within reach of resident
- Repositioning resident as needed
- Offering fluids
- Setting up/assisting resident with meal(s)
- Ambulating/transferring resident as needed
- Shaving resident as needed
- Cleaning wheelchairs weekly + PRN
- Checking residents' skin, report red or open areas to licensed staff
- Reporting BM status to licensed staff
- Obtaining vital signs as directed by licensed staff.

PM Cares:

- Dressing/assisting resident into appropriate bed clothing
- Removing dentures
- Providing oral hygiene
- Washing face & hands
- Combing/brushing hair
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room and assure that there is no personal belongings in pockets or tissues with clothing (laundry services will do an additional "pat down" of clothing prior to washing)
- Passing Water/Ice
- Tidying room
- Applying appropriate support devices as ordered/care planned
- Placing call light within reach of resident
- Repositioning resident as needed
- Offering fluids
- Setting up linens/blankets/pads as needed
- Setting up/assisting resident with meals
- Ambulating/transferring resident as needed
- Shaving resident as needed
- Check residents' skin, report red or open areas to licensed staff
- Obtaining vital signs as directed by licensed staff

NOC Cares:

- Changing resident clothing as appropriate
- Washing face & hands (if applicable)
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room and assure that there is no personal belongings in pockets or tissues with clothing (laundry services will do an additional "pat down" of clothing prior to washing)
-
- Passing Water/Ice
- Tidying room
- Applying appropriate devices/restraints as ordered
- Placing call light within reach of resident
- Repositioning resident as needed

Residents are not to be gotten up until approximately 0600 in the morning, unless it is resident request or a resident preference. The only exception to this would be if a resident is restless and is attempting to climb out of bed and places the resident at risk for falls or injury. These residents should be gotten up only if all other efforts to enhance sleep have failed. When residents are gotten up prior to 0600 the night staff will follow the above routine AM cares. If a resident is up early they are to be offered juice, coffee, reading material etc.

PERINEAL CARE

Residents should be given perineal care minimally each a.m. and p.m. and more frequently if needed. All residents wearing Incontinent Briefs will be checked in accordance with the personalized care plan. Residents will be cleansed after incontinent episode.

1. Gather supplies.
2. Educated resident about the procedure.
3. Perform hand hygiene.
4. Provide for privacy.
5. Don gloves.
6. Provide perineal cares, applying protective creams if ordered.
7. Clean up supplies, empty waste bin.
8. Doff gloves.
9. Perform hand hygiene.

Perineal and Skin cleanser are available and are kept at bedside for use during peri care. They will be stored in the resident bedside stand in cupboard.

If ambulatory, perineal care may be given on commode. If not, perineal care is given in bed. If decubitus ulcers are present, skin breakdown appears imminent, or any new skin issues are observed, the CNA providing care will contact the medication/treatment nurse assigned to their area so preventive measures can be instituted, ordered and added to the residents personalized care plan.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 21017 Revision) F880 – Infection Prevention and Control. 42 C.F.R. 483.80 (a)
- b. Centers for Disease Control and Prevention, *FAQs: Urinary Tract Infection (UTI) Events*. (Reviewed April 14, 2020). <https://www.cdc.gov/nhsn/faqs/faq-uti.html>.
- c. Centers for Disease Control and Prevention, *Types of Fungal Diseases*, (May 6, 2019). <https://www.cdc.gov/fungal/diseases/index.html>.

Revised 11/14, Revised 4/20

PASSING OF ICE WATER

Ice Water will be passed to the residents each shift by the CNA assigned to each floor or float aide if available.

When passing ice water, water will be offered to residents who normally cannot obtain it independently and during care times. Regular water containers will be changed weekly on the afternoon shift and sent to the kitchen for cleaning. A blue water pitcher will be utilized to identify residents on thickened liquids. It is to be change out EACH SHIFT and sent to the kitchen to be cleaned.

Ice cart will be cleaned q Sunday by night shift CNA and as needed.

MAINTENANCE OF URINALS

- Urinals are to be at bedside for resident use (when applicable).
- Urinals are to be checked frequently to ensure they are empty and rinsed.
- Urinals are to be collected and discarded weekly. This is to be done by NOC shift. A new urinal is then given to each resident with their name on it.
- Reminder: For infection control purposes urinals are not to be placed on same table as ice water or other food items. If a resident insists it be there the nurse should be notified so interventions can occur.

References:

- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii) Standard and transmission-based precautions to be followed to prevent spread of infections.

Revised 01/15, Revised 4/2019, 1/2020, 4/2020

BATHING PROCEDURE

Purpose:

This facility will provide quality resident grooming and hygiene to include bathing/showering of residents at a minimum of once weekly and/or resident preference.

Procedure:

Schedule:

1. Each unit's Resident Bathing Schedule will be developed per resident input/preference and updated by the Senior CNAs and/or RN Manager.
2. On day one of an admission or transfer to a wing a bathing schedule will be developed for the resident.
3. Bathing/showering will be conducted as scheduled. If a resident is unable or unwilling to bath/shower as scheduled -will be referred to the next shift until the process completed.
4. All baths/showers not completed as scheduled will be referred to the oncoming licensed nurse for assignment.

Documentation:

1. Bathing/showering of resident will be recorded on the specific resident in Care Tracker.
2. If a resident refuses a bath/shower then the CNA will document the ADL's section/Bathing of Care Tracker as ADL activity did not occur. Additional information about the refusal may also be documented in Care Tracker under the Mood and Behaviors (3.0) → Behavioral Symptoms 3.0 → Resists/Rejects evaluation of care → Refused bath or shower.
3. If a resident refuses a bath the licensed nurse assigned to that resident will be notified by the CNA.
4. Nurse assigned resident is responsible for ensuring the resident receives bath/shower per schedule and/or the resident's preference.

Bath Aide:

1. Bath Aides shall only be utilized to cover the floor in the event of staffing challenges.
2. The Bath Aide is responsible for the grooming and hygiene of the resident during the bathing/showering process including shampooing hair, shaving facial hair, etc. Bath Aide is responsible for trimming nails of NON diabetic residents (Licensed nurse trims nails of diabetic resident and other designated residents.)
3. The Bath Aide may assist the certified nursing aides in dressing/undressing the resident and changing bed linens, etc. (Bed linens are to be changed a minimum of once weekly, typically of the first bath day of the week.)

Revised 3/2013

OSTOMYCARE (Colostomy/Ileostomy)

Purpose:

Ostomy care is provided to promote cleanliness and to protect peri-stomal skin from irritation and infection.

Procedure:

Ostomy Care

Ostomy care is provided each shift and PRN by the certified nursing aide or licensed nurse assigned to resident. The resident may perform the procedure if competency has been demonstrated.

1. Identify the resident.
2. Explain the procedure to resident and provide privacy.
3. Wash hands before and after procedure and wear gloves.
4. Remove soiled appliance bag carefully, if applicable.
5. Open-ended appliance bags may be rinsed with lukewarm water and reapplied if the wafer is dry and intact.
6. Wash around the colostomy gently with lukewarm water and soap if necessary.
7. Avoid using soap if skin is moderately to severely irritated.
8. Communicate skin condition to the licensed nurse/medical provider as appropriate.

Wafer Attachment

This procedure shall be accomplished by the licensed nurse:

1. Apply colostomy appliance, ensuring appliance is securely adhered to the skin. (Follow physician's orders related to wafer type, skin prep, adhesive, change schedule, (typically 7-10 days and PRN if leakage), etc.)
2. Document ostomy status and skin condition in the specific resident's medical record and/or treatment sheet as appropriate.

URINARY CATHETER CARE

Purpose:

Catheter care is performed to minimize the risk of urinary tract infections and other complications by the presence of an indwelling urethral catheter.

Explanation

1. When emptying a catheter bag and opening the spout caution should be taken to not allow the end of the spout to touch anything that will contaminate it. Wipe the spout with an alcohol swab before and after emptying the catheter bag.
2. The catheter tubing must remain patent, with the drainage bag kept below the level of the bladder, to maintain unobstructed urine flow and prevent pooling and backflow of urine into the bladder.
3. Catheter care will be performed every shift and as needed by the nursing assistant.
4. Knock and gain permission to enter the resident's room.
5. Explain the procedure.
6. Provide privacy by closing the door, closing the blinds/curtains, pulling the room dividing curtain, etc.
7. Gather supplies needed.
8. Assist resident to a lying position or the most comfortable position for the resident.
9. Drape resident to expose only the perineal area.
10. Perform hand hygiene.
11. Don gloves

Procedure

Female:

12. Gently separate the labia to expose the urinary meatus.
13. Wipe from front to back with a peri wipes.
14. Use a new part of the wipe or new peri wipe for each side.
15. With a new peri wipe, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter.
16. Dry area with towel.

Male:

17. Gently grasp penis, draw foreskin back if applicable.
18. Using circular motion, cleanse the meatus with peri wipes.

19. With a new peri wipe, starting at the urinary meatus moving down, cleanse the shaft of the penis.
20. With a new peri wipe, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter.
21. Dry area with towel.

Both:

22. Bag and gather all supplies used, discarding disposable items in the trash can.
23. Assist resident to a comfortable, appropriate position.
24. Ensure call light is within reach.
25. Return room back to the original order.
26. Perform hand hygiene.
27. Document care and report any concerns noted to the nurse on duty.

References:

- d. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- e. Centers for Disease Control and Prevention, *Catheter-Associated Urinary Tract Infections (CAUTI)* (Reviewed November 5, 2015).
<https://www.cdc.gov/infectioncontrol/guidelines/cauti/>

Revised 5/18, 4/20

USE OF LEG BAGS/FOLEY BAGS

The catheter needs to be connected to a drainage bag to allow continuous drainage. It is important not to obstruct the flow of urine, unless you are specifically asked to do so.

Drainage bags vary in design but have a connection adapter for the catheter and a drainage port or spigot at the bottom to empty the bag. Some bags have long tubes so they can be attached to the bed or be carried. Other bags have no tubing and must be attached to one's leg with straps.

Cleaning of the drainage bags/connector tubing:

1. Wash hands and don gloves.
2. Disconnect the catheter where it connects to the tubing. Remove the cap from the leg bag tubing. Clean the end of the tubing with an alcohol swab. Connect the leg bag to the catheter.
3. Empty the urine from the large leg bag. Re-clamp the spout. Clean the spout with an alcohol swab and place the spout back into the holder. Clean the end of the tubing with an alcohol swab and cover with a cap to keep it clean.
4. Attach leg bag to opposite thigh each morning with elastic bands.
5. Empty leg bag as needed during the day (remember to wash your hands).
6. Repeat same procedure at night when changing back to the large catheter bag. Remember to clean the end with an alcohol swab and replace the cap.

Cleaning the drainage bags:

1. Wash hands.
2. Wear gloves.
3. Rinse the bag with warm water and empty it.
4. Combine two parts white vinegar with three parts warm water and pour into bag. (example: 2/3 cup white vinegar with 1 cup warm water) Allow to sit for 15 to 20 minutes. Then empty and rinse bag. Turn upside down to drip and air dry in soiled utility room.

Revised 01/15

PROSTHETICS

1. Prosthetics are to be ordered by the individual resident's primary physician.
2. Prosthetics will be care planned related to problem requiring the use of the device and the parameters for use.
3. Upon application and when removing a prosthetic, nursing staff will monitor stump site for any redness, swelling, bruising, other skin integrity problems and report these to the licensed nursing staff or physician, as appropriate.
4. Ensure site is prepared for prosthetic, as care planned/ordered e.g. tight-fitting stocking, skin barrier ointment, etc.

Reviewed 01/15

ROUNDS/ROUNDS CHECK LIST

1. Licensed staff and certified nursing aides assigned to each of the residents may conduct “walking rounds” at the end of each shift to ensure care were provided in accordance with the residents’ care plans and standards of care.
2. As requested by the RN Manager or as deemed necessary by the licensed nurse, the following “Rounds Check List” will be completed and signed by appropriate staff and submitted to the RN Manager for review.

DONE	TASK	COMMENTS
	Call lights are within reach of resident.	
	Resident is appropriately dressed (e.g. bed clothes).	
	Room is obstacle free.	
	Soiled linens and clothing are picked up.	
	Fresh water is at bedside.	
	Safety interventions are in place (e.g. alarms, ½ rails, floor mats, etc.).	
	Devices (e.g. heel protectors, foot cradles, splints) are on resident and appropriately applied.	
	Environmental/maintenance (e.g. wheelchairs, beds, light bulbs, electrical cords, room temperature.	
	h.s. (hours of sleep)	
	Oral care	
	Other:	

THIN CARBONATED BEVERAGE PROGRAM

Purpose:

It is the intent of this program to enhance the quality of life for those residents of ISVH-P who require nectar thickened Liquids.

Procedure:

1. Residents with diet orders that specify nectar thick liquids will be assessed by the Speech therapist for appropriateness prior to participating in the thin carbonated beverage program.
2. Based on the recommendation from the Speech therapist, the resident will be allowed thin carbonated beverages at his/her request.
3. Residents who are participating in the thin carbonated beverage program will have this identified on their plan of care.

Continued participation in this program will be reviewed periodically.

Updated 01/15

HOT BEVERAGE SERVICE PROCEDURE

Purpose:

It is the intent of this program to support resident choices in beverages with allowance for safety.

Procedure:

4. When serving residents, a hot beverage a lid must be placed to avoid spill resulting in possible adverse events.
5. If a resident prefers to drink hot beverages without a lid staff will meet with resident to discuss the risks and benefits and document their choice in their EMR.
6. Staff will then add their personal preference to have hot beverages served with no lid in their care plan.

References:

- f. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F804 – Food and Drink. 42 C. F. R. 483.60 (d)(2).
- g. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F689 – Accidents. 42 C. F. R. 483.25 (d).

5/2020

FEEDING A RESIDENT

Purpose:

The responsibility of the nursing staff is to provide assistance to residents who are unable to feed themselves or who need assistance with eating.

Procedure:

Feeding:

1. Ensure resident is positioned properly with clothing protector in place.
2. Ensure resident's diet is consistent with the meal served.
3. Ensure assistive devices are present.
4. Cut food into small, easily chewable pieces.
5. Feed resident slowly from tip of fork or spoon, offering an amount that is easily handled.
6. Place utensils in hand of resident and guide hand from plate to mouth as appropriate.
7. Encourage resident to choose the order of food eaten, when possible.
8. Avoid excessively hot or cold foods.
9. Record intake of fluids and solids on the meal monitor sheet.
10. Remove tray and leave resident clean and dry after feeding.

Assessment:

1. During the feeding/eating process, if a resident is noted to be pocketing food (food present in oral cavity – not swallowed completely), coughing or choking during any part of the meal consumption process, or voices or demonstrates any problems with eating all or any food offered; notify the licensed nurse assigned to the resident.
2. If an eating/swallowing problem is noted, the licensed nurse will notify the physician and unit manager and obtain a Speech Therapy evaluation/assessment as deemed necessary.

Frazier Free Water Protocol

Purpose:

Aspiration of water poses little risk to the resident if the oral bacteria associated with aspiration pneumonia are minimized. This allows residents who are NPO or on thickened liquids to have ice chips/water between meals when following specific guidelines. (The free water protocol is not appropriate for all residents. A speech language pathologist will determine if a patient is a good candidate for the protocol and will help implement the guidelines.)

Good oral hygiene is a key ingredient of the water protocol

1. There will be an identifier to remind all team members.
2. Mouth care during morning grooming, before and after meals, and snacks, before drinking water, and during evening grooming is a MUST. Mouth care consists of brushing and then rinsing with Perox-a-mint, a peroxide-based mouthwash.
3. Free Water (ice) will be allowed any time before meals and 30 minutes after a meal.
4. **NEVER** give medication with water. It must be taken in pudding or applesauce, with thickened liquid. If you are not allowed to eat or drink, you will receive medication through your feeding tube.
5. Encourage recommended compensatory strategies from speech therapist such as chin tuck or not using a straw.
6. Thicken liquids are offered during meal or snack time.

Allowing a patient free water

- A. Decreases the risk of dehydration
- B. Increases patient compliance with swallowing precautions
- C. Improves patient quality of life.
- D. Patient is allowed to drink water between meals and 30 minutes after meals.
- E. Oral care must be done prior to consuming water
- F. Patient should sit upright and use appropriate swallowing strategies.

Associated risks

- A. Aspiration during water-drinking trials with a benign event in most cases
- B. The risk of developing aspiration pneumonia is significantly greater if thick liquids or solid foods are aspirated
- C. Residents who aspirated thin liquids did not have a significantly different incidence of aspiration pneumonia than those who did not aspirate.

Created 10/16

MOUNT CARME Health Education (Letter to Resident)

When you have a swallowing disorder, you are at risk of developing "aspiration pneumonia." This type of pneumonia can occur if food or liquid gets into the lungs. "Thick liquids" are often recommended to help manage swallowing disorders. Adding thickness to liquids can make swallowing them safer.

Although it is safer, we know that residents who need thick liquids often fail to drink enough during the day. When you don't drink enough, dehydration can become an issue.

Your doctor has ordered the Frazier Free Water Protocol for you. In this program, you will be allowed to drink "free" (unthickened) water. When, provided along with good mouth care, water does not increase the risk for developing aspiration pneumonia.

While on the Frazier Free Water Protocol, you can expect the following things:

1. There will be an identifier to remind all team members.
2. You must do mouth care during morning grooming, before and after meals, and snacks, before drinking water, and during evening grooming. Mouth care consists of brushing and then rinsing with Perox-a-mint, a peroxide-based mouthwash.
3. You will be allowed to drink water any time before meals and 30 minutes after a meal. If you are not allowed meals, you can drink water at any time.
4. **NEVER** take your medication with water. You must take medications in pudding, applesauce, or thickened liquid. If you are not allowed to eat or drink, you will receive medication through your feeding tube.
5. Continue to use compensatory strategies that your speech therapist has recommended while eating or drinking such as using a chin tuck or not using a straw.
6. You must drink thick liquids during meal or snack time.
7. Under certain conditions you may drink water only under direct supervision. You will be told if this is the case.

If at any time you have questions about Frazier Free Water Protocol please contact your Speech-Language Pathologist.

SKIN CARE

Purpose:

In order to promote effective, timely application of skin protective lotion, creams, and moisture barriers, the following procedure will be followed.

1. In conjunction with a resident's plan of care, skin protective lotion, creams, and/or moisture barrier cream may be kept at the resident's bedside and administered per direction from the care plan and licensed nurse(s).
2. The above skin care products will be used to prevent skin breakdown and skin conditions. The licensed nurse will administer skin products that are being used to treat an acute skin condition.

The aide is responsible for reporting any changes in skin condition to the licensed nurse for further evaluation.

SUCTION EQUIPMENT MAINTENANCE

1. Suctioning will be done when ordered by a physician or in the event of an emergency situation.
2. Suctioning will be administered by a licensed nurse.
3. Resident's requiring deep or tracheal suctioning will be referred to the RN Manager for evaluation and further intervention.
4. Suction machines are located in the treatment room, chart room and in the large dining room.
5. Suction canisters will be readily available on the units and when put into use will be labeled with the name of the resident and date the canister was put into use.
6. Suction canisters/tubing should be covered while in the room and not in use.
7. Suction catheters and tubing will be dated when put into use and changed Q24 hours and PRN.

Canisters assigned to residents will be discarded when 2/3rds full of when suctioning is no longer necessary. Canisters should be placed in a biohazard bag will and be disposed of by storekeeping staff upon notification.

AT NO TIME SHOULD STAFF ATTEMPT TO OPEN A USED CANISTER TO REMOVE OR DISCARD CONTENTS.

SUCTIONING

Purpose:

Tracheostomy suctioning is provided to maintain an airway, prevent aspirating from food or sections and allow for removal of tracheal-bronchial secretions.

Procedure:

1. Explain procedure to resident and provide privacy.
2. Perform hand hygiene, gown, mask, face shield (unless an airborne/aerosolized pathogen is present then a N95 would replace the mask) and gloves.
3. Place resident in semi-Fowler's position.
4. If a fenestrated tracheostomy tube is in place, insert a plain inner cannula prior to suctioning.
5. Select catheter. Catheter must be no more than half the internal diameter of the respiratory tube in situ. e.g. Trach tube internal diameter 10mm. (38 gauge) - suction catheter external diameter 4.5mm (14 gauge).
6. Turn on suction pressure gauge, checking that the pressure is between 100-200mm HG.
7. Open suction catheter pack and attach suction port end to the suction tubing, leaving remainder of catheter in protective sleeve.
8. Remove catheter from protective sleeve, ensuring that the part of the catheter to be inserted into the trachea remains sterile (do not touch).
9. Lubricate catheter tip with sterile saline while catheter control valve is uncovered.
10. Ask patient to take a couple of deep breaths or deliver extra oxygen for 2 minutes.
11. Observe the patient closely throughout the procedure.
12. With vacuum, control port open insert catheter carefully into tracheostomy tube just past distal end of the tube (approximately 1/3 of the length of the catheter).

13. If resistance is felt, withdraw 1-3cms. (If the catheter rests against the tracheal mucosa it will cause trauma, if it rests against the carina it will stimulate the vagus nerve with the potential for hypotension and cardiac arrhythmia.)
14. Apply suction pressure by occluding the vacuum port.
15. Slowly withdraw the catheter without rotation and within 10 seconds.
16. Allow resident a rest period and replace oxygen or humidified air over tracheostomy.
17. Repeat steps 8-14 not more than once if necessary.
18. Wrap suction catheter around dominant hand and remove glove inside out over catheter.
19. With non-dominant hand, flush suction tubing with water until clear.
20. Remove gloves including catheter and discard into trash, remove gown, perform hand hygiene, remove protective eye cover and mask. Don clean gloves and wash protective eye cover, doff gloves and perform hand hygiene.
21. Chart procedure, amount and nature of secretions, patient's tolerance of procedure.
22. Inform Charge Nurse of any adverse reactions.
23. Never allow secretions collecting in suction bottle to exceed 500cc.
24. Canisters assigned to residents will be discarded when 2/3rds full of when suctioning is no longer necessary. Canisters should be placed in a biohazard bag will and be disposed of by storekeeping staff upon notification.

TRACHEOSTOMY CARE

All tracheostomy care is performed by a licensed nurse in response to a physician's order. Tracheostomy care should be performed at least once a day and PRN as needed.

Equipment Preparation:

1. Obtain equipment including sterile tracheostomy tray, sterile normal saline, suction equipment, hydrogen peroxide, scissors, and sterile Q-tips.
2. Wash hands before and after treatment and wear gloves.
3. Open tracheostomy tray that contains:
 - a) sterile gloves
 - b) sterile Q-tips
 - c) plastic basins
 - d) tracheostomy tapes
 - e) wire brush
4. Fill one basin with hydrogen peroxide and another with normal saline.
5. Saturate three Q-tips in hydrogen peroxide and three in normal saline. Place in third empty basin.

Resident Preparation/Procedure:

6. Explain procedure to resident and provide privacy.
7. Place resident in semi-Fowler's position
8. Perform hand hygiene
9. Put on clean gloves, gown, mask and eye protection.
10. Remove inner cannula and place in hydrogen peroxide and let soak.
11. Suction entire length of outer cannula.
12. Discard used suction catheter.
13. Remove soiled dressing and discard.
14. Remove gloves, perform hand hygiene and put on a set of sterile gloves.
15. Using wire brush, insert it into inner cannula to remove any secretions.

16. Place inner cannula in basin of normal saline to wash off hydrogen peroxide, shake off excess saline.
17. Replace inner cannula and lock in place.
18. Clean around stoma with Q-tips, alternating hydrogen peroxide and normal saline.
19. Using precut tracheostomy dressing, place around tracheostomy.
20. If tracheostomy tapes are soiled, replace them. Cut a slit approximately 1 to 1 ½ inches from end of new tapes. Place tapes through tracheostomy openings and tie before removing soiled tapes.
25. Discard materials, if pathogen is present, discard in in a biohazard bag will and be disposed of by storekeeping staff upon notification.
21. Remove gloves, remove gown, perform hand hygiene, remove protective eye cover and mask. Don clean gloves and wash protective eye cover, doff gloves and perform hand hygiene
22. Document in medical record the amount and character of drainage, condition of stoma and skin, and other pertinent observations.
23. Inform Unit Manager of any adverse reactions.

References

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 21017 Revision) F880 – Infection Prevention and Control. 42 C.F.R. 483.80

10/09 Reviewed 02/15, 4/20

FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION

1. PURPOSE

Each resident at Idaho State Veterans Home – Pocatello (ISVH-P) has the right to be free from exploitation, verbal, sexual, physical and mental abuse, serious bodily injury, corporal punishment and involuntary seclusion. Further, each resident/patient at ISVH-P will be treated with respect and dignity at all times.

In accordance with Section 1150B of the Social Security Act as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010, ISVH-P requires all employees, managers, supervisors, agent, and contractors to report any reasonable suspicion of crimes committed against a resident. The ISVH-P follows state and federal guidelines regarding resident care and works in collaboration with the Bureau of Facility Standards, the Veterans' Administration and local law enforcement to ensure rules and standards regarding resident/patient care are upheld. State and federal regulations require the ISVH-P to report certain events in accordance with 42 CFR § 483.12 (a)(i), and IDAPA 16.03.02.100.12 (c) and (f).

“CRIME” is defined by law of the applicable political subdivision where the ISVH-P facility

is located. The facility must coordinate with local law enforcement entities to determine what actions are considered crimes within their political subdivision. It has been determined that the following defined actions may be considered a crime and are reportable:

2. DEFINITIONS

“ABUSE,” is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 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. “MENTAL ABUSE” is the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.
- b. “VERBAL ABUSE” may be considered a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.
- c. “SEXUAL ABUSE” is non-consensual sexual contact of any type with a resident.
- d. “PHYSICAL ABUSE” includes hitting, slapping, pinching, biting, kicking, etc. It also includes controlling behavior through corporal punishment.
- e. “INVOLUNTARY SECLUSION” means separation of a resident/patient from other residents or from his or 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 period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the residents’ needs.
- f. “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.
- g. “MISAPPROPRIATION OF RESIDENT PROPERTY” means the deliberate misplacement or wrongful temporary or permanent use of a resident’s belongings or money without the residents consent.
- h. “INJURY OF AN UNKNOWN ORIGIN” are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and the injury includes severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the

body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities does not meet this definition and need not be reported.

- i. "EXPLOITATION" means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
- j. "EXPLOITATION THROUGH PHOTOGRAPHY OR VIDEOS" To prevent the taking and use of photographs or video of residents that the resident (or their representative when they can't make their own decisions) have not granted consent or believes may be demeaning or humiliating. Taking or distributing of any photographs or video recordings of a resident or his/her private space without the resident's or designated representatives, written or verbal consent must not be done by any employees, consultants, contractors, volunteers, or other caregivers at ISVH-P. Examples include, but are not limited to, staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), a resident eating in the dining room, or a resident participating in an activity in the common area. Should a photograph or video recording be taken unintentionally; they must be destroyed unless the resident (or their representative should the resident be unable to consent) provides consent. While residents may give consent for taking of photographs or videos, the use of those photographs must be consistent with the consent and cannot be demeaning or humiliating. Using photographs or video recordings in ways not covered by the consent may be inappropriate. Any photograph(s)/video(s) should ideally be shared with resident or their representative prior to use to make sure they do not find it humiliating or demeaning. Staff must report to their supervisor any unauthorized (or suspected to be unauthorized) taking of photographs or videos as well the sharing of such recordings in any medium. Violation of this policy may result in disciplinary actions including up to termination. All staff, consultants, contractors, volunteers and other caregivers will be educated about this policy as part of their orientation prior to providing services to residents.

*Note: written or verbal consent requires the resident to understand the implications of their consent. Also, residents (or their representative if they are unable to consent) may change their consent at any time, which should be documented.

3. IMPLEMENTATION AND SCREENING

- a. Residents of ISVH-P will not be subjected to any of the above defined crimes by anyone, including but not limited to, facility staff, other residents, consultants, contractors, volunteer staff, family members, friends or other individuals. The first person who has knowledge of any act of abuse, neglect, exploitation or misappropriation of resident property shall report such information to the Administrator either through a phone call or email immediately. Additionally, this person will notify their immediate supervisor or the Charge RN on duty, who shall immediately report such information to the DNS, Social Worker, and law enforcement if applicable. The reporting person will also fill out the Gold Suspected Abuse/Neglect/Exploitation Witness Report immediately located on each nursing unit.
- b. ISVH-P will not employ individuals who have been found guilty of abusing, mistreating,

exploiting or neglecting residents by a court of law or individuals who have had a finding entered into the state Nurse Aide Registry concerning abuse, mistreatment or neglect. The Idaho Board of Nursing will be contacted for information on licensed nursing applicants. ISVH-P will also refrain from employing any individual who has been prohibited from working in a long-term care facility because of failure to report a suspicion of a crime against a resident of another long-term care facility. Further, no person shall be employed at ISVH-P who discloses, is found to have been convicted, or has a withheld judgment as an adult or juvenile of any of the disqualifying offenses as described in IDAPA 16.05.06, "Criminal History and Background Checks." Criminal history checks shall be completed on all staff employed at ISVH-P - per the Divisions' Criminal History Background Check Procedures.

- c. All alleged violations will be thoroughly investigated by the facility under the direction of the Home Administrator and in accordance with state law.
- d. Idaho State reporting requirements will be adhered to including reporting to the appropriate law enforcement agency. The Home Administrator or his designee shall report to the state licensing authority, Bureau of Facility Standards, all allegations of violations of this procedure and the results of the facility investigation. These shall be reported to the appropriate officials within the time frames established by the Bureau of Facility Standards.
- e. ISVH-P facility shall post conspicuously in an appropriate location a sign specifying the rights of employees under Section 1150B of the Social Security Act.

4. REPORTING REQUIREMENTS

- a. Facility reporting of all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Bureau of Facility Standards' Reporting Portal www.ltc-portal.com

Bureau of Facility Standards (208) 334-6626

Bureau of Facility Standards' Facsimile (208) 364-1888

Pocatello City Police Department (208) 234-6100

Idaho Board of Nursing (208) 334-3110

- b. When employees, managers, supervisors, agent, and/or contractors (herein after referred to as "covered individuals") reasonably suspect a crime has occurred against a resident they must report the incident to the Bureau of Facility Standards and local law enforcement.
- c. Covered individuals can use the facility form to report a suspicion of a crime. However, there is no requirement to use the form.

- d. Covered individuals can either report the same incident as a single complaint or multiple individuals may file a single report that includes information about the suspected crime from each covered individual using the facility form.
- e. If, after a report is made regarding a particular incident, the original report may be supplemented by additional covered individuals who become aware of the same incident. The supplemental information may be added to the form and must include the name of the additional staff along with the date and time of their awareness of such incident or suspicion of a crime. However, in no way will a single or multiple person report preclude a covered individual from reporting separately. Either a single or joint report will meet the individual's obligation to report.
- f. Events causing reasonable suspicion of a crime (as defined above), must be reported by covered individuals as follows:
 - 1. Reasonable Suspicion with Serious Bodily Injury- 2 hour limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion;
 - 2. Reasonable Suspicion without Serious Bodily Injury- within 24 Hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion.

“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.

- g. Covered individuals must also report the suspicion of a crime to the Administrator either through a phone call or email immediately. Additionally, the covered individual will notify their immediate supervisor or the Charge RN on duty, who shall immediately report such information to the DNS, Social Worker, and law enforcement if applicable. The covered individual will also fill out the Gold Suspected Abuse/Neglect/Exploitation Witness Report immediately located on each nursing unit.
- h. Failure to report in the required time frames may result in disciplinary action, including up to termination.
- i. The Administrator or his/her designee is responsible for providing the Bureau of Facility Standards the completed investigation report within 5 working days of the alleged abuse.
- j. Retaliation against any individual who lawfully reports a reasonable suspicion of a crime under section 1150B of the Social Security Act is strictly prohibited.

5. TRAINING

- a. This procedure is mandatory reading for all new employees. They will receive a copy of this procedure at new employee orientation and will sign documentation to verify they have read and understand this procedure.
- b. ISVH-P will notify covered individuals annually of their individual reporting obligations to comply with section 1150B (b) of the Act and included herein these nursing procedures.
- c. Mandatory training will be provided to all staff at ISVH-P regarding the content of this procedure. The content of this training shall include identifying appropriate interventions in dealing with aggressive and/or catastrophic reactions of residents; the reporting requirements of this procedure and the ability to make such reports without the fear or concern of reprisal; recognizing signs of distress in employees that may lead to possible abuse; and the definition of what constitutes abuse, neglect, exploitation and misappropriation of resident property. All ISVH-P employees and ISVH contracted entities shall undergo this training at least on an annual basis.

“CATASTROPHIC REACTIONS” can be defined as reactions or mood changes of the resident. In response to what may seem to be minimal stimuli such as bathing, dressing, toileting, etc., that can be characterized by unusual responses such as weeping, anger, or agitation.

6. PREVENTION

- a. It is the Procedure of ISVH-P that prevention is the first line of defense against any inappropriate behavior directed toward residents. In addition to a pre-employment screening through criminal history checks, mandatory training, and mandatory reporting requirements, all employees are expected to be well informed of the elements of this policy and each employee shall certify that they have read the policy and are familiar with its content. Further, each resident, family member, or responsible party shall be notified in writing at the time of admission about how and to whom any report suspected incident of abuse, neglect, exploitation or misappropriation of property may be made. This information shall also include assurances that such reporting may be made without fear of retribution and that full protection shall be provided to the resident who may be the subject of alleged abuse during any investigative process that ensues.
- b. Staffing of direct care positions shall meet or exceed state minimums at all times on all shifts. Proper supervision of those staff will include direct observations during the provision of care with special attention given to any inappropriate behavior on the part of the caregiver such as using derogatory language, rough or improper handling, ignoring legitimate requests of residents, ignoring toileting needs, etc.
- c. Careful attention will be given to all residents during the assessment and care planning processes for residents who may have special needs because of behaviors such as

aggressiveness, catastrophic reactions, self-injury, nonverbal communication, or those who require heavy or total nursing care. These residents are to be viewed as especially vulnerable and deserving ongoing protection.

7. IDENTIFICATION

- a. All events which warrant reporting via the facility Incident/Accident reporting system shall be tracked so as to be able to identify suspicious events, occurrences, patterns or trends that may constitute abuse or neglect. The Home Administration shall be responsible for monitoring this tracking system and shall determine when a preponderance of the data indicates that an investigation is necessary.

8. PROTECTION AND INVESTIGATION/EVALUATION

- a. All suspected cases of abuse, neglect, exploitation and misappropriation of resident property will be investigated following the guidelines set forth by the Bureau of Facility Standards. The Home Administrator of ISVH-P, or the Acting Administrator in his absence, shall be responsible for directing the investigation and complying with all reporting requirements. The Administrator may enlist the services of other professionals to assist with the investigation.
- b. Following receipt of an allegation, the facility will take appropriate measures to ensure that no further potential crime(s) will occur while the investigation is in process. Any employee under investigation for violation of this policy will be removed from the facility and may not work at any Idaho State Veterans Home until the investigation is completed. The employee may be also placed on Administrative Leave with Pay from employment for up to thirty (30) days under the provisions of IDAPA 15.04.01.109.02. If necessary, the thirty (30) day suspension period may be extended with written approval from the Administrator of the Idaho Division of Human Resources. If an employee is placed on administrative leave during the investigation, the employee will be notified in writing by the Administrator, explaining reason of employee leave and availability expectations during the investigation process.
- c. The following steps will be utilized to assist in ensuring a thorough investigation is completed related to the alleged incident:
 1. After the covered individual has reported alleged incident to Administrator and the RN Charge or Nurse Manager, the RN Charge or Nurse Manager will immediately notify Director of Nursing, and the Director of Social Services. Other appropriate Department/Team Leaders will be notified if applicable to begin investigation of alleged incident.
 2. If the allegation is abuse, neglect, or exploitation related, Social Services or designee will take the lead. If the investigation is clinically related, i.e. fall with major injury, the Director of Nursing or Designee will take the lead. Reporting requirements as outlined in this procedure under section 4 will be followed. During the investigation, the QI Director and the Administrator will be kept informed of the progress of the investigation. The following steps will be taken with investigations:
 - a) Social Services and supervisors will conduct interviews with resident's and

resident witnesses identified in the investigation.

- b) Social Services and supervisors will conduct Interviews and obtains written, dated and signed statements from direct care staff assigned to resident. Depending on the incident, it may be necessary to obtain statements from direct care staff one to two shifts prior.
 - c) Social Services and supervisors will conduct interviews and obtain written, dated and signed statements from staff witnesses or other available witnesses, i.e. volunteers, agency, contractors and family members
 - d) For an employee who has been placed on administrative leave, Social Services and the employee's supervisor (or designee) will make arrangements to conduct a face-to-face interview either at ISVH or the Central Support Office conference room.
 - e) The facility has five (5) business days to conclude the investigation with the allegation either being verified or not verified. Social Services will formulate a final detailed investigative report that will be submitted to Bureau of Facility Standards Reporting Portal no later than the fifth day of when the investigation began.
 - f) If at the conclusion of the investigation the employee placed on administrative leave is called to return to work, the employee will be provided with written notification by the Administrator outlining the results of the investigation, including disciplinary action and/or training, if any, necessary for corrective action. The employee will have the opportunity for Due Process. IDAPA 15.04.01.200.
- d. The nurse progress notes should reflect, but are not limited to, the following:
- 1. Who was involved in the incident? Include staff, residents, and visitors.
 - 2. Where did the incident occur? Include physical location, was it cluttered, well lit, busy, etc.
 - 3. What was the time of the incident?
 - 4. What was the situation leading up to the incident?
 - 5. What was the situation immediately following the incident?
 - 6. Where was the staff prior to, during, and after the incident?
 - 7. What did the staff do immediately to ensure the safety of both residents?
 - 8. Was there any physical injury and if so, how was the injury addressed?
 - 9. What was the resident's emotional status?
 - 10. Who was notified: Administrator, DNS, DSS, family?
 - 11. Were there any changes in medication?
 - 12. Were there any recent changes in physical condition; i.e.: infection?
 - 13. Was the care plan amended?
- e. Nurse progress summary notes at the end of each shift for 72 hour may include:

1. The emotional state of the resident(s).
2. Any verbal or physical aggression towards others.
3. Any change in medication.
4. Any physical changes.
5. Interventions used.

f. The Administrator or his/her designee is responsible for providing the Bureau of Facility Standards the completed investigation report within 5 working days of the alleged abuse

11/00; Revised 10/03, 03/11, 09/11, 03/13, 03/15, 02/17, 05/17, 06/19, 08/19, 02/2020

REASONABLE SUSPICION OF A CRIME AGAINST A RESIDENT REPORTING FORM

<p>INSTRUCTIONS: Contact and submit this completed form to the Bureau of Facility Standards and Pocatello City Police Department within 2 hours (if there is serious bodily injury) or 24 hours (if there is not serious bodily injury) of forming a reasonable suspicion that a crime may have been committed against any individual who is a resident of the Idaho State Veterans Home – Pocatello. <u>IDAHO STATE VETERANS HOME CONTACT:</u> Josiah Dahlstrom, Administrator 1957 Alvin Ricken Dr., Pocatello, Idaho 83201 Phone: (208) 235-7800 Fax: (208) 235-7801 Email: Josiah.dahlstrom@veterans.idaho.gov</p>	
<p>Reported to the State Survey Agency? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Reported: ___/___/___ Time: _____</p> <p>BUREAU OF FACILITY STANDARDS CONTACT: 3232 Elder Street, PO Box 83720, Boise, ID 83720 Reporting Portal www.ltc-portal.com</p>	<p>Reported to the Local Law Enforcement? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Reported: ___/___/___ Time: _____</p> <p>POCATELLO CITY POLICE DEPARTMENT CONTACT: 911 N. 7TH Avenue, Pocatello, Idaho 83205 Phone: (208) 234-6100 911 – Emergency General Fax – (208)234-6247</p>
<p>Provide a summary of the suspected crime including the resident name and date of birth, as well as a brief description of the location of the incident and, if available, the names of any individuals involved in the suspected crime. (Attach additional sheets if necessary. No. of pages attached _____)</p> <p>Resident Name: _____ DOB: _____ SSN#: _____</p> <p>Description & Location of Incident:</p> 	
<p>Was there serious bodily injury as a result of the incident? No ___ YES ___ (must be reported within 2 hours)</p>	
<p>INDIVIDUAL[S] REPORTING</p>	
<p>THIS REPORT IS MADE BY THE FACILITY ON BEHALF OF ALL COVERED INDIVIDUALS LISTED BELOW.</p>	
<p>Name:</p>	<p>Date/time individual became aware of suspected crime</p>
<p>1.</p>	<p>Date: ___/___/___ Time: _____</p>
<p>2.</p>	<p>Date: ___/___/___ Time: _____</p>
<p>3.</p>	<p>Date: ___/___/___ Time: _____</p>

4.	Date: ___ / ___ / ___	Time: _____
5.	Date: ___ / ___ / ___	Time: _____
6.	Date: ___ / ___ / ___	Time: _____
7.	Date: ___ / ___ / ___	Time: _____
8.	Date: ___ / ___ / ___	Time: _____

NOTE: This report is required by law where a suspicion a crime has occurred and is in no way an admission by the person(s) submitting the report that a crime has actually occurred.

Revised: 01/2014, 04/16, 05/17

VIII PHARMACY

PHARMACY SERVICES

The Idaho State Veterans Home — Pocatello shall have a written agreement with a pharmacist currently licensed and in good standing by the State of Idaho to direct, supervise, and be responsible for all pharmacy services in the facility.

The pharmacist shall be responsible for:

1. Reviewing the medication profile for each individual patient at least every thirty (30) days.
2. The attending physician shall be advised of drug therapy duplication, incompatibilities, and/or contraindications.
3. Reviewing all medications in the facility for expiration dates.
4. Removal of discontinued or expired drugs from use as indicated at least every thirty (30) days.
5. Reviewing the facility for proper storage of medications and dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any non-compliance.
6. Reviewing the narcotic and dangerous drug records at least every thirty (30) days and certifying to the administrator that the inventory is correct.
7. Participating in the formulation of pharmacy service policies and procedures in conjunction with the administrator, director of nursing services, and physician responsible for the medical direction of the facility.

Medications shall be administered to the resident only on the order of a person authorized by the law in Idaho to prescribe medications. The order shall be recorded on the resident's medical record, dated, and signed by the ordering physician, dentist, or nurse practitioner.

DRUG DISPENSING TO FACILITY

Medication Labeling/Cassettes

1. Medications will be dispensed throughout ISVH-P using the bubble pack system.
2. All medications (bubble pack) will be labeled with the name, strength of medication, manufacturer's name, lot identification number, expiration date, and initials of pharmacist dispensing.

Pharmacy Availability

1. Pharmacy/prescription availability will be 24 hours through on call services.
2. New medication orders will be filled within a 24 hour period, except in those cases where the resident's condition requires immediate dispensing of a medication as determined by physician orders.
3. In cases of a medication dose increase, the existing dose will be continued until the new ordered dose is available, unless specifically requested by the physician.

Pharmacy Access

1. Access to the facility Pharmacy will be limited to the Director of Pharmacy Services and a Pharmacy Technician.

FLOOR STOCK MEDICAL SUPPLIES

Certain medications shall be available within the facility for occasional use where the pharmacy source is not immediately available. All medication inventories contained within the floor stock medication supply are the property and responsibility of the pharmacy and it will be the responsibility of the pharmacist to maintain records for these medications

1. A standardized, locked and/or sealed medication supply will be kept in the locked satellite pharmacy.
2. Pharmacy staff will maintain inventory as well as a master list of all medications contained in the supply kit and will ensure that drugs are in adequate supply.
3. The kit medications needs, including deletions and additions will be assessed and approved by the Pharmacy, DNS, and Medical Director.
4. Licensed nursing staff will sign out medications on the appropriate forms when used from the kit to include the name of the drug, the patient's name, date, and time of removal signed with nurse's complete signature.
5. The pharmacist will be responsible for reviewing the sign-out sheets and restocking as necessary.
6. The pharmacist will be responsible for replacement and disposal of expired medications.

MEDICATION ADMINISTRATION & MEDICATION ORDERS

Responsibility

1. Medications shall be administered to residents only on the order of a person authorized by law in Idaho to prescribe medications.
2. Medications will be dispensed by a Registered Professional Nurse (RN) or a Licensed Practical Nurse (LPN) who has completed an accredited school of nursing and has a current and unrestricted license to practice nursing in the State of Idaho under the guidelines set forth by the Idaho Nurse Practice Act.
3. The Certified Nursing Assistant (CNA) will not dispense or administer medications.

Medications/Medication/Treatment Carts

1. Medication carts should be disinfected at shift onset and prn when soiled or potentially contaminated.
2. Medications will be passed directly from cart drawers.
3. No medications will be “stored” on the top of the medication cart.
4. No medications will be set up prior to administration.
5. Medication carts will be kept locked when not in use.
6. All fluids and food used for medication pass will be dated and covered.
7. All fluids and food will be discarded after 24-hours (typically at the end of the night shift).
8. All food/fluids requiring refrigeration will be discarded at the end of each shift.
9. To protect the resident’s right to privacy, the resident record shall be covered when the nurse is away from the cart and the EMAR will be in locked.
10. Medications that have been set-up and not given or refused (also refer to Controlled Substances) shall be wasted.

Medication Administration

1. Nursing’s process (six rights) will be noted before the administration of each medication.
2. Any medications coming in contact with possibly contaminated surfaces, such as but not limited to: medication cart, staff hands, ect., should be wasted following appropriate procedure.
3. Hand hygiene shall be performed after approximately every five (5) medication passes or as needed if resident, residents' environment, other staff, ect touched.
4. **Administration of Metered Dose Inhalers (MDI)**
 - a) The nurse will wait at least one (1) minute between inhaler puffs of same medication and five (5) minutes between different medications.
 - b) Administer MDI in proper sequence if more than one type is used Bronchodilator-Anticholinergic-Miscellaneous-Corticosteroids.
 - c) When using a steroid MDI, then following completion of inhalation then instruct the resident to gargle or rinse their mouth with water and spit. Caution resident not to swallow the water.
5. The nurse will wait at least 3-5 minutes between each eye drop.
6. There must be a physician’s order to crush medications.
7. **Do not crush** medications that should not be crushed unless the physician or pharmacist has explained, in the clinical record, why crushing the medication will not adversely affect the resident. (Must observe for pertinent adverse effects from crushing the med.).
8. Provide adequate fluids with medications.

9. Medications that require the nurse to “shake well” will be done just prior to administration.
10. Insulin should be “rolled” to mix prior to administration.

Standard Medication Times and Orders

DOSING INTERVAL	HR	HR	HR	HR
QD	0800			
BID	0800	1700		
TID	0800	1200	1700	
QID	0800	1200	1600	2000
Q6H	0800	1400	2000	0200
Q12H	0800	2000		
AC	0700	1100	1600	
HS	2000			
SNACKS	1000	1500	1900	

* In collaboration with the physician, the nurse may change standard medication times and notify the unit secretary.

1. All telephone (TO) and verbal orders (VO) shall be taken by a licensed nurse, pharmacist, or physician.
2. All TOs / VOs shall be countersigned by the ordering physician or nurse practitioner.
3. Medication order shall include the resident’s diagnosis, the name of the medication, the route to be given, the dose and time(s) to be administered.
4. Nursing staff is responsible for verifying that the order has been entered correctly in the EMAR or ETAR.
5. Licensed nurse noting any change (dosage change, frequency change, ect) to orders shall ask the medication nurse to either turn the card backwards or place the old card in the bottom drawer of the medication cart for removal by pharmacy. (Note: if the medication is a controlled substance, medication should be wasted and signed off by two nurses using the bottle of deactivation medium.)

Medication Administration Documentation

1. **The nurse will check in the EMAR box when the medication is removed from the blister pack/container.**
2. Medications checked on EMAR will be saved **after** given.
3. PRN Medications will be charted on the progress notes with reason with follow-up results an hour later. Injections will also include site documentation.
4. When a resident refuses a medication, the nurse will document on EMAR and progress notes the reason.
5. When a medication is not given within one hour of the scheduled time, then the nurse will indicate the reason in progress notes after marking the medication given in EMAR. PRN narcotic medication must be given at time frame specified by the MD order.
6. When a resident has a scheduled narcotic medication and a PRN narcotic medication, the PRN medication may be given no sooner than one (1) hour after the administration of the routine narcotic medication.

Revised 10/16, Revised 4/20

References:

- h. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)

MEDICATION ADMINISTRATION: FEEDING TUBES

Purpose:

To assure that medications administered via feeding tube are administered safely and accurately. A physician's order is required for the administration of any medication via feeding tube. Liquid dosage forms should be ordered if available and prudent.

Procedure:

1. A physician's order is required for the administration of any medications via feeding tube. The order must specify the medications, dosage route (tube), frequency, and volume of water to be administered with the medications.
2. Most oral medications with the exception of enteric coated and enzyme specific medications can be administered through an enteric feeding system. Questions regarding the compatibility of the medications with the enteric system should be directed to the pharmacist.
3. Tablets are crushed and capsules are opened to facilitate mixing and administration. Tablets should be crushed to a fine consistency. Powder from crushed tablets or capsule contents should be mixed well in at least 30 ml of water or other prescribed diluents.
4. Multiple medications may be administered at the same time unless contraindicated due to incompatibility.
5. The feeding tube will be flushed with at least 30 ml of water before and after the administration of medications.

TUBE FEEDING

Purpose:

Tube feeding will be utilized only after adequate assessment, and the resident's clinical condition makes this intervention necessary.

Procedure:

1. The enteral nutrition order must include the following: if appropriate:
 - a) Type/brand of feeding to be used.
 - b) Quantity/amount of each feeding.
 - c) Number of feedings.
 - d) Number of total feeding calories and total volume of enteral product administered in 24 hrs.
 - e) Method of instillation e.g. gravity/pump.
 - f) Flow rate.
 - g) Route (i.e., PEG tube, naso-gastric tube).
 - h) Amount of additional water flushes.
 - i) Diagnosis supporting enteral feeding intervention.
2. Prior to the instillation of the enteral feeding staff shall:
 - a) Check for residuals, feeding should be held if residual is > 100mL, document. Recheck in 1 hour, if residual is still >100ml, hold and notify physician.
 - b) Check for proper tube placement, document.
3. The tube insertion site shall be monitored for redness, swelling, drainage, etc.; prior to each feeding and PRN, findings documented.
4. Tube site shall be cleaned q day and PRN with soap/warm water or as ordered by the clinical specialist.
5. Prior to and following the instillation of enteral feedings/medications the tube shall be flushed with at least 30cc of warm water or as directed by physician.
6. Staff is responsible for monitoring resident for feeding complications such as vomiting, diarrhea, gastric distention, aspiration and administering corrective actions.
7. Resident's head shall be elevated at least 30-45 degrees during and at least 30 minutes following each feeding.
8. Enteral feeding equipment shall be dated, stored, and changed appropriately.
 - a) Irrigation syringe shall be rinsed with hot water following each use, dated and placed in clean container (may be stored in the resident's room). Discard every 24 hours.
 - b) Open formula systems shall not hang > 8 hours.
 - c) Tubing shall be discarded every 24 hours.
9. Staff shall use universal precautions when preparing and instilling the enteral feeding.

INJECTION AND DERMAL PATCH SITE DOCUMENTATION

Purpose:

Licensed nursing staff will document each injection site to ensure adequate rotation of sites. Licensed nursing staff will document location of each dermal patch site to ensure adequate monitoring and removal.

Procedure:

1. Every injection/dermal patch order will have a designated time of administration and a site indication listed on the individual resident's MAR (Medication Administration Record).
 - a) Licensed staff will initial in the appropriate time/day/shift box after the medication is administered.
 - b) Licensed staff will indicate in the appropriate site box, the location of the injection site and/or placement site of the dermal patch using one of the following abbreviations. It is anticipated that the injection/placement site will rotate among the appropriate sites.
 - i. RA—Right arm
 - ii. LA—Left arm
 - iii. RAB - Right abdomen
 - iv. LAB-Left abdomen
 - v. LT—Left thigh
 - vi. RT-Right thigh
 - vii. LG — Left gluteal
 - viii. RG-Right gluteal
 - ix. LUB — Left upper back
 - x. RUB — Right upper back
 - xi. LC—Left chest
 - xii. RC — Right chest

MEDICATION RECALL

1. The Director of Pharmacy, on receipt of a drug(s) recall, shall notify the facility and staff with the guidance of the pharmacist will immediately check all stock for the recalled lots of the medication.
2. Any noted medications found will be returned to the ISVH-P pharmacy.
3. If the recalled medications could be harmful to the resident, pharmacy services will make a list of all residents that may have received the recalled drug(s).
4. The Pharmacist will notify the Medical Director with the information.
5. All residents who received the medication will be assessed by the provider for any possible complication(s) the recalled medication may have caused.

MEDICATION STORAGE/DISPOSAL

1. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station and locked when not in use.
2. The key for this cabinet shall be carried only by the licensed nursing personnel and/or the pharmacist.
3. The Director of Pharmacy is responsible for ensuring proper storage of medications and dangerous chemicals.
4. The Director of Pharmacy is responsible for the identification and disposal of all expired medications in the facility.
5. Poisons and toxic chemicals shall be stored in separate locked areas apart from medications.
6. External use only medications shall be stored only in a separate, locked area apart from internal use medications, all medications will have appropriate labeling.

Resident Medications:

1. All medications brought by a resident will be sent home with families. If no family is available, medications will be stored and given to residents upon dismissal from the facility. If the medications are stored for over 30 days, they will be destroyed with proper witness and documentation by the Director of Pharmacy.
2. If it is determined that there is a compelling reason to use the resident's own medication, a physician's order is required. Examples of valid justification may be unusual medications which the pharmacy has difficulty obtaining.
3. The physician order shall specify that the resident's own medication is to be used and the name of the drug, the dose and the directions/reason for use.
4. The prescription must be identified by the pharmacist and it must be properly labeled. The pharmacist will affix another identifying label certifying the contents.
5. The nurse will store the authorized medications with other routine medications.
6. The nurse will administer the medication(s) and record use on the medication administration record.
7. If the medication is anticipated to be accessible to the resident then a self-medication assessment needs to be completed.

MEDICATION/PRESCRIPTION RE-ORDERING

Pharmacy completes weekly checks on all bubble packing and fills as needed. If after hours should something be needed the nurse will:

1. Notify the pharmacy via FAX of new order.
2. Call the on-call pharmacist.

(If Hospice patient, the nurse will notify the Hospice nurse who will be responsible for getting the medication.)

AUTOMATIC STOP ORDERS

Purpose:

To limit the duration of drug therapy in the absence of the prescriber's specific indication of duration of drug therapy.

Procedure:

1. All medications in use in the facility will be covered by the Automatic Stop Order procedure.
2. Automatic Stop Order Time Limits are as follows:

DRUG CATEGORY	STOP ORDER
Antibiotics (including topical)	10 days
Any medications – non-use	90 days

3. Pharmacy will be responsible for determining whether or not there is a legitimate continuing need for the medication in question.
4. The prescriber may override the automatic stop date by specifying a particular duration with the initial order.
5. The Pharmacist will communicate with the nursing department their recommendations related to medication discontinuation in conjunction with the monthly drug regimen review.
6. The RNC (or designee) will initiate the physician notification and discontinuation order.

Revised 02/15

CONTROLLED SUBSTANCES

Purpose:

Pharmacy services, nursing, and physicians will act in concert to ensure the safety, security, monitoring, and management of all controlled substances. The appropriate laws, regulations, mandates, and official directives will be observed both for intent and procedure.

Procedure:

Controlled Substance Storage

1. All controlled substances will be locked in the narcotics cabinets at all times.
2. All controlled substances will be accounted for with a running inventory, at the direction and discretion of pharmacy services.
3. All controlled substances used by residents will be signed out to nursing as needed to meet the needs of the resident's medication orders. After the narcotics have been signed out, licensed nursing staff will be held accountable and responsible for the appropriate dispensing and documentation as mandated by the Idaho State Nurse Practice Act.
4. All used controlled substance sign-out sheets will be stored in the pharmacy.
5. The pharmacist shall review the entire inventory of controlled substances at least every thirty (30) days.

Controlled Substance Inventory Count/Errors

1. At the end of each shift, the licensed nursing staff will account for all controlled substance inventory.
2. The oncoming nurse will physically count each controlled substance and the outgoing nurse will verify the count against the inventory sheets.
3. If there is a discrepancy in the inventory count, the nursing staff will attempt to reconcile the sheets/inventory, and notify the RNM, the DNS, or Pharmacist regarding any unaccounted for narcotics.
4. No licensed nurse shall leave the unit/floor until the drug inventory and/or error has been accurately reconciled unless by permission of the Director of Nursing Services.
5. If the discrepancy cannot be resolved within a reasonable length of time, the Director of Nursing Services shall be contacted for further instructions, who will notify the Pharmacist
6. Any nurse who leaves the facility with medication keys shall be immediately notified and return (in person) to the facility with the keys.

CONTROLLED SUBSTANCES DESTRUCTION POLICY

Policy:

Controlled substances at the Idaho State Veterans Home – Pocatello are stored under double lock on behalf of the ultimate user. Authorized personnel may destroy the controlled substances on behalf of an ultimate user who resides, or has resided at this long-term care facility. This may occur due to death, discontinuation of the prescription, or discharge. Destruction of controlled substances shall be done in a way as to make them non-retrievable.

Procedure:

1. Controlled medications will be destroyed to a non-retrievable state by two authorized personnel via the Rx Destroyer.
 - a. Authorized personnel will be determined by the Director of Nursing. One must include a charge nurse at time of destruction
 - b. Each Rx Destroyer will be labeled with a number correlating with the number on the Controlled Substance Destruction Log.
2. Two authorized personnel will remove controlled substances from blister pack or container and place in Rx Destroyer.
 - a. Load medications into the bottle.
 - b. Tightly replace cap.
 - c. Gently shake to mix solution over medications.
 - d. Empty controlled medication cards will be returned to pharmacy.
3. Destruction must be recorded on the corresponding narcotic sheet for the controlled substance being destroyed and on the Controlled Substance Destruction Log. Both authorized personnel will sign both sheets.
 - a. The narcotic sheet will be placed in the binder behind Destruction Log.
4. The Rx Destroyer is full when contents are 2 inches from the cap. **DO NOT OVERFILL.**
 - a. Discard into garbage and obtain replacement from store keeper.
 - b. Two witnesses must sign and date the Destruction Log at time of disposal of Rx Destroyer.
 - c. Completed Destruction Log will be returned to pharmacy to be stored for record along with Narcotic Sheets.

ACCIDENTAL BREAKAGE OR CONTAMINATION/PARTIALLY USED CONTROLLED SUBSTANCES/WASTAGE

1. The licensed nurse will summon another licensed nurse to co-sign the amount of the controlled substance that has been wasted.
2. In the witnessing wastage of controlled substances, the licensed nurse shall not sign any record attesting to the wastage of controlled substance medications unless the wastage was personally witnessed.
3. The licensed nurse shall not solicit the signatures on any record of a person as a witness to the wastage of controlled substance when that person did not witness the wastage.
4. The lost amount will be entered and deducted from the balance on the next unused line of the controlled substance administration record.
5. If this entry does not suffice as explanation, further details should be entered on the back of the form.
6. A damaged drug will be wasted by two nurses.
7. Both the nurses will sign and time the entry of the wasted medication.
8. When the size of a prescribed amount of drug necessitates the use of a partial ampule/medication, the whole number consumed will be entered in the dose column. In parentheses along-side of this entry, the actual amount given to the patient will be entered, and the quantity wasted will be noted and initialed.
9. Expired, discontinued controlled substance medications will returned to the pharmacy.
10. No licensed nurse will ever sign out and then delegate to another nurse to give a resident's medication or falsify nursing or CNA signatures.
11. The nurse shall act to safeguard the patient from incompetent practice.
12. The nurse shall report to the Director of Nursing Services any licensed nurse who is grossly negligent or reckless in performing nursing functions.
13. The Director of Nursing Services will investigate the issue and report any adverse findings or violations of the Nurse Practice Act to the Board of Nursing as well as consult ISVH department of personnel.

Reviewed 02/15

MEDICATION ERRORS/OMMISSIONS

1. A Medication and Treatment Errors and Omissions report will be completed upon identification of any of the following:
 - a) wrong dose
 - b) wrong medication
 - c) omitted medication(s)
 - d) wrong resident
 - e) wrong time (to include not being within the one hour time allotted)
 - f) Wrong route.
2. All licensed nurses will be responsible for reporting, investigating, and documenting any medication error as well as initiating and completing the medication error form.
3. The completed report will be submitted to the DNS who will review, complete any missing information, and conduct any necessary counseling.
4. Medication and Treatment Errors and Omissions report(s) will be routed through the DNS and Pharmacy within 24 hours of the discovery. Other disciplines involved will be notified as needed.
5. All reports will then be reviewed for follow-up as necessary.

Revised 02/2015, 01/2020

**IDAHO STATE VETERANS HOME – POCATELLO
MEDICATION ERROR REPORT**

DATE OF REPORT: _____
(Top section to be completed by nurse finding error)

Name of Resident Effected: _____

Physician: _____

Nurse that Made Error: _____

Date of Med Error: _____

Medication Involved: _____

Dose Administered: _____

What was the Physicians Original Order: _____

Source of information regarding the medication given (circle one): MAR Verbal Order PCC Chart

Type of Error (circle all that apply):

Transcription Error	Dose Omission	Reaction to Medication*	Wrong Dose
No Order	Wrong Time	Pharmacy Filling Error	Wrong Patient*
Wrong Medication	Procedure Error	Wrong Route	Occurred for Numerous Days *
On Critical Drug List*	Other (explain below):		

Severity of Error: _____ *CRITICAL (Resulted in adverse effects – **NOTIFY PHYSICIAN IMMEDIATELY**)

_____ NON-CRITICAL (Did not result in adverse effects—*Physician can be notified via fax*)

Name of Nurse Finding Error: _____

Physician Notified Date: _____ Time: _____ By: _____

Pharmacy Notified Date: _____ Time: _____ By: _____

COPY to RN Manager Date: _____ Time: _____ By: _____

ORIGINAL GIVEN TO RESPONSIBLE NURSE TO COMPLETE Date: _____ BY: _____

*****Please Attach Copy of Med Card and Administration Record Confirming Error*****

(Below to be completed by nurse that created the error)

Explanation of error:

What will you do to prevent this error from occurring again:

Signature :

Date of completion:

SUBMIT COMPLETED FORM FOR ADMINISTRATIVE REVIEW (Administrative review on back) ›

**IDAHO STATE VETERANS HOME – POCATELLO
MEDICATION ERROR REPORT**

Reviewed By:

DNS: _____

Date: _____

ADMINISTRATOR: _____

Date:

MEDICAL DIRECTOR: _____

Date:

ADVERSE MEDICATION REACTIONS

Drug Allergies:

1. Allergies to medications will be noted on the physician's order sheet, the care plan, and the medication administration record.
2. Allergies will be indicated on a label placed on the front of the resident's medical record.

Drug Interactions/Reactions:

An adverse drug reaction is a pathological condition precipitated by a drug, including toxicity caused by overdose, hypersensitivity or allergy.

3. The Director of Pharmacy, nursing staff, and physician are responsible for monitoring the possible interactions that may occur.
4. If there are concerns related to the use of a medication then the medication should be withheld until the physician has been notified regarding the concerns.
5. In the event that a drug intervention/reaction occurs, the licensed nurse assigned to resident shall complete a Medication and Treatment Error and Omissions/Adverse Drug Reactions form.

Drug Regimen Review

6. The Pharmacy Department is responsible for reviewing each resident's drug regimen on a monthly basis to monitor for any adverse medication reactions.
7. The pharmacy report will be submitted to the nursing department for review and consultation with the resident's physician, when applicable.
8. Upon review by the physician, the DNS or RN Manager will complete the needed changes, keep a copy of the review, and return the original form, with completed actions, to the pharmacy.

SELF-ADMINISTRATION OF MEDICATIONS

If a resident requests to self-administer medication(s), the facility ITD will determine if it is safe for the resident to exercise that right. The following steps will be utilized in determining and implementing this right.

1. The medications will be evaluated to determine if it is appropriate and safe for self-administration. Typically only life-saving prescription drugs such as bronchodilators and nitroglycerin will be approved for self-administration and storage at resident's bedside. Non-medicated OTC products will not be impacted by this procedure and may be kept at bedside.
2. A self-Administration of Medication assessment (located in PCC) will be completed and the results of the assessment will be available to the ITD team to assist with their determination. This assessment includes but is not limited to assessment of:
 - a. Resident's physical capacity to swallow medications without difficulty.
 - b. Resident's ability to open medication bottles/containers.
 - c. Resident's cognitive status, including their ability to correctly name the medication and know what conditions it is taken for.

- d. Resident's capability to follow directions and know the time(s) when medications need to be taken.
 - e. Resident's comprehension of instructions for the medication they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
 - f. Resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.
 - g. Resident's ability to ensure that medication is stored safely and securely (locked box).
 - h. Resident's ability to communicate to licensed nursing staff when and how much of the medication they self-administered.
3. Upon ITD approval for a resident to self-administer medication(s) a physician's order will be obtained to include name of drug, dosage, frequency, route, diagnosis, and the right to keep at bedside.
 4. A proper storage place for the medication will be determined, to include ensuring the medication is locked in a secure location and is only available to the resident (if stored in the resident's room) and/or licensed nursing staff.
 5. Licensed nursing staff will document the medication administration in the eMar.
 6. Resident's right to continue to self-administer medications will be re-evaluated by the ITD at least quarterly, in conjunction with the MDS schedule and in the event the resident experiences a change of condition that may impact their ability to self-administer medications.
 7. Resident's care plan and medical record will be updated to include the self-administration of the medication(s) and any specifics related to this administration.

9/2018

Self-Medication Administration Assessment

Date: _____

Nursing Assessment:

The purpose of self-administration medication form within P.C.C is related to nitroglycerin and bronchodilator use. The form will be completed for a resident to provide self-administration of medication after the setup by the nurse. The form is for assistance with medication and does not indicate total independence on the part of the resident.

Revised 02/15, 9/17

MEDICATION REFRIGERATOR TEMPERATURES

1. Any medications requiring refrigeration must be stored in the Pharmacy, separate from any foods items or specimens.
2. Medications will be stored in their appropriate containers or labeled by the Pharmacist.
3. Refrigerator temperature must be maintained between 36 - 46 degrees Fahrenheit.
4. Refrigerator temperatures must be obtained daily and documented at the beginning of the day shift and recorded on the Refrigerator Temperature Record Form.

STANDING ORDERS

DEFINITION:

A *standing order* is a one-time order that is written for a concern that is acute and is expected to resolve within 72 hours (three days). The order must specify how long it will remain in effect; a period not to exceed 72 hours (three days).

PROTOCOL:

The following are standing orders the primary physician/medical director has agreed to and signed. If there is no signed standing order list for a resident's physician (e.g. hospice physicians) the licensed nurse must contact the physician. The licensed nurse writing the standing order will make a note in the resident's chart, including an assessment of the resident. Standing orders are not to be used on a routine basis. When a resident has an on-going need for a standing order, the licensed nurse will obtain a routine order for that medication from the primary physician.

- 1. ANALGESIC/ANTIPYRESIS:** For minor aches and pains and/or a fever greater than 101° F (oral).
 - a) Acetaminophen 325mg ii tabs PO Q 4 hours PRN minor aches and pains or a temperature >101° F (oral); Not to exceed (NTE) 3 grams. APAP 24 hours from all sources.
- 2. BOWEL CARE / CONSTIPATION**
 - a) Use Bowel Protocol
- 3. CHEST PAIN (ANGINA)**
 - a. Oxygen @2L/min per NC continually for chest pain.
 - b. Nitrostat (Nitroglycerin) 0.4 mg. sublingual Q 5 minutes x 3 doses.
 - c. Notify physician for further orders.
- 4. COUGH / SORE THROAT**
 - a. Guaifenesin Syrup, 10 ml PO Q 4 hours PRN cough.
 - b. Cepacol lozenges 1 lozenge PO Q 2 hours PRN cough.

5. DIARRHEA

- a) Immodium 4mg initially, followed by 2mg after each loose stool. May not exceed 16mg daily.

6. DRY EYES:

- a) Artificial tears 1.4% gtt in both eyes Q 1 hours PRN dryness/minor irritation.

7. DYSPEPSIA:

- a) Mylanta suspension or generic equivalent antacid. Give 30cc PO Q 2 hours as needed for gastric distress up to 200 cc/day X 3 days.
- b) Calcium Carbonate tablet chewable 500mg. Give ii tabs PO Q 2 hours as needed for the GI distress up to 10 tabs Q day X 3 days.

8. DYSPNEA/SOB/OXYGEN SAT <90%:

- a) Administer O2 @ 1-4 liters/mm via NC PRN SOB and to maintain O2sat > 90%. (For flow rates above 3 liters/min for extended periods of time, a humidifier needs to be added to assist with prevention of nasal drying). Notify physician for new or escalating O2 requirement.

9. IMPACTED CERUMEN:

- a) Cerumenex / Debrox 6.5% (or equivalent) ii gtt in affected ear(s) x 4 days @ HS, flush ear(s) on the fifth night.

10. NAUSEA / VOMITING:

- a) Promethazine HCL (Phergan) 12.5 mg. IM 0.25ml, PO, or suppository Q 6 hrs PRN Nausea and/or vomiting X 48 hrs.
- b) Zofran 4mg SL Q 6 hrs PRN nausea and/or vomiting X 48 hrs.

11. POST FOLEY DISCONTINUATION:

- a) Bladder scan Q 6 hrs and following a void (PVR) X 3 days. Straight catheter if >500 cc. Notify physician if scans >500 cc continue through 3rd day.

12. SKIN TEARS:

- a) Cleanse area gently with normal saline or soap & H₂O & pat dry.
- b) Approximate edges
- c) Apply Steri-Strips
- d) Cover with non-adhering gauze pad and protect as needed with gauze dressing or Kerlix.
- e) Observe for signs and symptoms of infection Q day until healed.
- f) Write order for S.T. dressing changes

13. TOOTH (ORAL) PAIN:

- b) Viscous Xylocaine 2%. Apply topically to affected oral area with swab Q2 hours PRN tooth (oral) pain

14. URINARY TRACT INFECTIONS:

- a) Adhere to strict criteria when deciding to perform a chem-10 urine dip test. A very large percentage of nursing home residents carry white blood cells and bacteria in their urine at all times, a condition called "asymptomatic bacteriuria (AB)." If a chem-10 urine dip is performed on a resident with AB, the results will seem to show infection, and will likely lead to inappropriate over-use of antibiotics, which can cause harm in multiple ways. Foul smelling urine and cloudy urine are not valid reasons to perform a chem-10 urine test in a resident who is otherwise at baseline.
- b) Criteria for performing a chem-10 urine dip test on residents with no indwelling urinary catheter:
 1. Acute dysuria

OR

2. Fever > 100.0 F or 2.4 degrees F above usual temp **AND** at least one of the following **new or worsening** findings:
 - Urgency to urinate
 - Frequency (the need to urinate more often than usual)
 - Suprapubic pain (pain in the center of the low abdomen just above the pubic bone)
 - Gross hematuria (you can see blood in the urine)
 - Costovertebral angle tenderness (tap the lumbar back just below the lower ribs)
 - New urinary incontinence
 - New onset of delirium (new confusion or hallucinations above baseline mental state)

OR

3. No Fever or chills with two or more of the following symptoms:
 - Urgency to urinate
 - Frequency (the need to urinate more often than usual)
 - Suprapubic pain (pain in the center of the low abdomen just above the pubic bone)
 - Gross hematuria (you can see blood in the urine)

- New/Increased urinary incontinence
- c) Criteria for performing a chem-10 urine dip test on residents with an indwelling urinary catheter (one of the following symptoms must be present):
1. Fever > 100.0 or 2.4 degrees F above usual temp
 2. New Costovertebral angle tenderness (tap the lumbar back just below the lower ribs)
 3. Rigors (shaking chills)
 4. New/dramatic change in mental status (new confusion or hallucinations above baseline mental state)
- d) Notify physician or designated provider for orders if positive chem-10 urine dip.
- e) UA using clean catch, and if necessary utilize straight or condom cath, when ordered by physician or designated provider.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. November 2017 Revision) F881-Antibiotic Stewardship Program. 42 C.F.R. 483.80 (a)(3).
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F690-Urinary Incontinence. 42 C.F.R. 483.25 (e)(2)(iii).
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 21017 Revision) F880-Infection Control. 42 C.F.R. 483.80(a)(2).
- d. CDC, *Healthcare-associated Infection Surveillance Protocol for Urinary Tract Infection (UTI Events for Long-term Care Facilities*. January 2020).
<https://www.cdc.gov/nhsn/pdfs/ltc/lcf-uti-protocol-current.pdf>
- e. CDC, *Hai Checklists*. Reviewed December 10, 2019). <https://www.cdc.gov/nhsn/hai-checklist/>
- f. 2020 NHSN *Urinary Tract Infection (UTI) check list* (January 2020)
<https://www.cdc.gov/nhsn/pdfs/checklists/uti-checklist-508.pdf>
- g. JSTOR, *Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGreer Criteria* (October 2012)
https://www.jstor.org/stable/10.1086/667743#metadata_info_tab_contents

15. INFLUENZA VACCINATIONS:

- a) Infection prevention nurse or designee will coordinate with pharmacy vaccination availability to coordinate vaccination schedule.
- b) Infection prevention nurse or designee will work with office support staff to mail the CDC vaccination information sheet and consent form. Once form is completed from is returned this will be given to the unit clerk to be scanned into the residents electronic medical record.
- c) Infection prevention nurse or designee will enter orders in to PCC for injection, turning the injection order copy to pharmacy.
- d) Infection prevention nurse will then enter orders for alert charting in PCC and update the Alert Charting document on the N drive, giving updated copies to the charge nurse.
- e) The licensed nurse will make a note in the resident's chart, including an assessment of the resident for (afebrile, not currently take antivirals, egg allergy, and moderate or severe illness).
- f) The nurse will enter an order for a one time dose of Fluzone High-Dose Suspension Prefilled Syringe 0.5 ML (Influenza Vac Split High-Dose) into the patients electronic medical record.
- g) Following best nursing practice administration, the resident is to be placed on alert charting for approximately 72 hours. During this time, the nurse will inspect the vaccination site and obtain the resident's temperature daily to endure there is no adverse reaction.

16. PNEUMOCOCCAL VACCINATIONS:

- a) On admission infection prevention nurse or designee in conjunction with pharmacy will review resident's immunization records to assess for need/appropriateness to receive Pneumococcal Conjugate (PCV 13) or Pneumococcal Polysaccharide (PPSV).
- b) Infection prevention nurse or designee will work with office support staff to mail the CDC vaccination information sheet and consent form. Once form is completed from is returned this will be given to the unit clerk to be scanned into the residents' electronic medical record.
- c) Infection prevention nurse or designee will enter orders in to PCC for injection, turning the injection order copy to pharmacy.
- d) Infection prevention nurse will then enter orders for alert charting in PCC and update the Alert Charting document on the N drive, giving updated copies to the charge nurse.
- e) The licensed nurse will make a note in the resident's chart, including an assessment of the resident for (afebrile and moderate or severe illness).

- f) Following best nursing practice administration, the resident is to be placed on alert charting for approximately 72 hours. During this time, the nurse will inspect the vaccination site and obtain the resident's temperature daily to ensure there is no adverse reaction.

17. SUSPECTED SEPSIS/SIRS EMERGENCY TRANSPORT:

- a) If any changes are noted in a resident: changes in mentation (increased confusion/disorientation or new onset changes), SOB, Vital signs out of normal range or changes in resident presentation (clammy, diaphoretic, shivering or unusually cold).
- b) Charge Nurse will then use the laminated Modified Early Warning Score (MEWS) sheet and calculate the previous week score then calculate the current score using full vitals and resident mentation.
- c) If there is a change in score greater than 2 points then orders need to be written in PCC for immediate transport to the emergency department.
- d) Once emergency procedure has been followed a secure conversation stating the 2 scores as well as observed changes in mentation and physical presentation to the provider and time of the emergency transport order.

(MEWS chart next page)

Signature _____

Date _____

Revised 6/2018, 2/2019

MODIFIED EARLY WARNING SCORE (MEWS)
--

			last Week	Current Week
Systolic BP	=/<70 mmHg	+3		
	70-80 mmHg	+2		
	81-100 mmHg	+1		
	101-199 mmHg	0		
	=/>200 mmHg	+2		
Heart Rate	=/<40 bpm	+2		
	41-50 bpm	+1		
	51-100 bpm	0		
	101-110 bpm	+1		
	111-129 bpm	+2		
	=/>130 bpm	+3		
Respiratory Rate	<9 bpm	+2		
	9-14 bpm	0		
	15-20 bpm	+1		
	21-28 bpm	+2		
	>29 bpm	+3		
Temperature	<95 F	+2		
	95-100.4 F	+1		
	=/>100.5 F	+2		
AVPU	Alert	0		
	Reacts to Voice	+1		
	Reacts to Pain	+2		
	Unresponsive	+3		
Total Score Last Week				
Total Current Score				

Triggers for calculating the MEWS:

1. Changes in mentation (increased confusion/disorientation or new onset changes)
2. SOB
3. Vital signs out of normal range
4. Changes in presentation (clammy, diaphoretic, shivering or unusually cold)

****IF A CHANGE OF 2 POINTS +/- IS NOTED PLEASE SEND TO ED PER STANDING ORDERS****

18. ISOLATION PRECAUTIONS:

The Infection Preventionist, or designee will serve as a consultant to facility staff on infectious diseases and the implementation of isolation precautions, using the CDC 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings Appendix A. [F483.80 (a)(2)]

- a. Isolation precaution orders will specify type (contact, droplet or airborne), related pathogen and if applicable length of time for the isolation. (for specific order implementation procedure please see the Transmission Based Precaution ISVH-P procedure)
- b. Discontinuation of isolation precaution orders will follow DCD recommendations, with consultation from the Infection Preventionist, or designee.

19. THREE OR MORE LIQUID STOOL WITHIN A 24 HOUR PERIOD:

- a. Obtain a stool sample for C. Difficile PCR send to lab STAT. Stool must be liquid.
- b. Place resident on contact precautions in a single room, if possible.
- c. Notify Provider via secure conversation.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880- Infection Prevention and Control. 42 C.F.R. 483.80 (a)(e)(f).
- b. Siegel JD, Rhinehart E., Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation> .
- c. Centers for Disease Control, *Strategies to Prevent Clostridioides difficile Infection in Acute Care Facilities*, <https://www.cdc.gov/hai/prevent/cdi-prevention-strategies.html> .

6/2019

HYPOGLYCEMIA

Purpose:

To define the standard protocol for treatment of hypoglycemia.

Definitions:

Hypoglycemia – occurs when the blood sugar is below 80 and the body begins to respond. Diabetic residents with severe neuropathy may no longer have early warning symptoms and the first signs or symptoms may be impaired central nervous system function such as confusion, twitching, seizures or unconsciousness. **When the blood sugar is below 80 utilize the Hypoglycemia Treatment Reference Guide**

1. **Mild to Moderate Hypoglycemia** – Blood sugars are between 40-80 mg/dl. Typical presentation includes shakiness, dizziness or lightheadedness, weakness, pale skin, sudden change in behavior or mood, trembling, sweating, nervousness, hunger, peri-oral tingling, mood changes, headache, blurred vision, restlessness and slurred speech. The resident can typically swallow safely.
2. **Moderate to Severe Hypoglycemia** – Blood sugar is less than 40 mg/dl. Blood sugars less than 20 may cause severe coma or seizures. The resident may be conscious but generally is confused or less responsive. The resident often has lost the ability to swallow safely.

Treatment:

Glucose Gel – A glucose supplement in gel form that can be placed under the tongue or in the cheek.

GlucaGen – a hormone that raises blood glucose that is given IM for low blood glucose when swallowing is questionable.

Medications that (may) cause Hypoglycemia:

Medication	Onset of Action	Time to peak effect	Duration of action
Insulin – Regular	About 30 min.	2 – 4 hours	5 – 8 hours
Insulin – NPH	About 2 hours	6 – 10 hours	18 – 28 hours
Combination 70/30	About 30 min.	2 – 10 hours	18 – 24 hours
Glipizide (oral diabetic med)	1.5 - 2 hours		12 – 24 hours
Glyburide (oral diabetic med)	2 – 4 hours		18 – 24 hours
Metformin (Glucophage) (oral diabetic med)	2 – 2.5 hours		10 – 16 hours
Insulin Glargine (Lantus)	1.5 hours	Peak effect 5 hours	24 hour

Monitoring for Hypoglycemia

1. Residents who are administered insulin or oral diabetic medications will be monitored every shift for any signs/symptoms of hypoglycemia. Licensed nurse will intervene per Hypoglycemia Treatment Reference Guide, as appropriate.
2. Monitor shall read: Monitor resident for sign and symptoms of hypoglycemia e.g. shakiness, sweating, confusion, weakness; intervene per reference guide. Note:

Signs/symptoms of hypoglycemia may be masked in diabetic residents who are taking a beta-blocker(s).

Blood Glucose Levels/Interventions

1. Finger-stick blood sugar (FSBS) levels shall be obtained by an approved CNA or licensed nurse, as ordered, and PRN based on assessment and FSBS levels. For FSBS <80 mg/dl, refer to Hypoglycemia Treatment Reference Guide.
2. Documentation for residents experiencing hypoglycemia, shall include a nursing assessment of any signs/symptoms the resident is demonstrating/experiencing and their resolution.
3. If a FSBS was not obtained as ordered e.g. resident out of facility, resident already consumed meal, etc., then the licensed nurse shall document the reason in PCC

Holding Insulin:

1. Licensed nurse may hold insulin if the blood glucose level is <70 mg/dl (and intervene per the Hypoglycemia Treatment Reference Guide and notify provider per parameters).
2. Licensed nurse may hold AC (before meals) insulin if the resident is not expected to eat within 30 minutes of the insulin administration and notify the provider.
3. Licensed nurse shall document actions for decision in the progress notes in PCC.

Signature _____ Date _____

Revised 02/18

HYPOGLYCEMIA TREATMENT REFERENCE GUIDE PER ADA GUIDELINES

Category	Symptoms	Response
Blood Glucose 70-80 mg/dl	No Symptoms	<ol style="list-style-type: none"> 1. Give a mixed meal that includes protein source-nuts, seeds, cheese, meat, PB&J, etc 2. Recheck blood glucose in 30 minutes 3. May hold any diabetic medications including insulin if BC <70 mg/dl 4. Notify physician per order parameters 5. Document all interventions in Nurse Progress Notes/eMar
MILD TO MODERATE HYPOGLYCEMIA Blood Glucose 40-70 mg/dl	ALERT WITH SYMPTOMS Confusion, delirium, dizziness not so frequent- palpitations, sweating, tremors ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. Give one of the following <ol style="list-style-type: none"> a. Nuts, seeds b. Cheese, meat, PB&J sandwich. 2. Give low fat meal or snack 3. Hold any diabetic medications including insulin 4. Recheck blood glucose after 30 minutes 5. If glucose<40 mg/dl treat as moderate to severe hypoglycemia below 6. If glucose still 40-70 mg/dl repeat treatment per step #1 above and recheck BG in 15 minutes 7. If glucose >70 mg/dl, give low fat meal or snack, recheck BG in 15minutes and follow reference guide 8. Notify physician per order parameters 9. Notify family/responsible party 10. Document all interventions in Nurse Progress Notes/eMar
MODERATE TO SEVERE HYPOGLYCEMIA Blood Glucose <40 mg/dl	ALERT ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. Give 1 tube oral glucose gel 15 g. tube PO and 2. Give low fat meal or snack 3. Hold any diabetic medications including insulin 4. Recheck blood glucose after 15 minutes 5. If blood glucose still <40 mg/dl repeat step #1 above and recheck BG in 15 minutes 6. If blood glucose still <40 mg/dl give glucagen 1 mg. IM in upper arm or thigh and recheck BG in 15 minutes 7. If blood glucose still <40 mg/dl or resident becomes unresponsive call 911 8. If glucose >40 mg/dl but < 70 mg/dl & able to swallow, repeat step #1 above and give low fat meal or snack and recheck BG in 15 minutes 9. Notify physician ASAP for further instructions 10. Notify family/responsible party 11. Document all interventions in Nurse Progress Notes/eMar
MODERATE TO SEVERE HYPOGLYCEMIA Blood Glucose <40 mg/dl	UNRESPONSIVE UNABLE TO SWALLOW SEIZURES ARE POSSIBLE	<ol style="list-style-type: none"> 1. CALL 911 2. Notify physician 3. Notify family/responsible party 4. Hold any diabetic medications including insulin 5. Assess airway, check vital signs, protect from falls and injuries from possible seizures 6. Give glucagen 1 mg IM in upper arm or thigh 7. Recheck BG in 15 minutes and obtain vital signs 8. If blood glucose still <40 mg/dl repeat glucagen 1 mg IM in upper arm or thigh 9. If resident regains consciousness and is able to swallow give 1 tube glucose gel 15 g p.o. and give low fat meal or snack 10. If resident remains unresponsive continue to monitor airway and pulse, intervene per POST as necessary.

Updated 3/26/2018

TRANSCRIBING MEDICATION/TREATMENT ORDERS

Standard:

Proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents. This is achieved by using the Point Click Care computer program.

Policy:

Medications and treatments ordered by a physician, including telephone orders, must be taken and noted by a licensed nurse. They will be placed in PCC by ward clerk or LN. If ward clerk enters the orders those orders will be placed in que and licensed nurse must review for accuracy and approve them for EMAR. The paper orders will be reviewed by the DNS or deisgnee.

- Rehabilitation treatment orders can be written by a licensed physical therapist, speech therapist, and occupational therapist but must be noted and cosigned by a licensed nurse. If speech therapist is recommending a change of diet then this must be communicated to the dietary department. These orders are to have the same procedure followed as T.O. and V.O. orders.
- Consultation forms must be noted by a licensed nurse. These orders must also follow the procedure for transcribing T.O. and V.O.
- Physicians use the written orders when writing orders, a licensed nurse must note the order. Physicians have up to 7 days to sign any and all orders received by the LN via telephone, verbal or standing order.
- The ward clerk will make necessary changes to the appropriate forms, etc. when ordered. In the ward clerk absence the LN (s) on duty will make the necessary changes.

Procedure:

1. Receiving a written order:
 - a) Orders must be written by a physician on the resident medical order sheet or via consult form.
 - b) LN check to ensure the order is complete which will include date, time, diagnosis and physician signature.
 - c) The order is to be noted off by a LN and processed by Ward Clerk or LN.
2. Receiving a telephone or verbal order:
 - a) Before terminating conversation with the physician repeat the order to clarify and ensure that the following necessary information is included: Medication, dosage, route of administration times and/or frequency of administration, number of days or doses, and reason (indication-dx.) for medication/treatment.
 - b) The order is to be written immediately on physician order sheet exactly as it was given. The date ordered and the time ordered must be included. At the end of the written order you must write TO, or V.O and the physician name/LN signature. When using a routine standing order you must also write at the end of the order RSO. Complete all needed information on the order sheet: do not leave any areas blank.

- c) Notify resident and/or family. Check on order sheet who was notified, date notified, name person contacted. This must be done prior to administering the first dose of medication or doing the first treatment.
- d) Transfer order into PCC
- e) Make a complete nursing notation in the PCC nursing progress notes as to the order obtained, why it was obtained, resident and/or family notified (give name of family member).
- f) Update the resident care plan and initial on order sheet as being done.
- g) Sign the order sheet when completed including date and time.
- h) Communicate the new order by utilizing the 24 hour report sheet/ or PCC or the communication book whichever is appropriate.

After receiving the order:

1. If Ward Clerk is on duty: the Ward Clerk is to process the order, by taking the pink sheet to pharmacy and give the original order and green sheet to the Charge Nurse. The Charge nurse will check for accuracy, take the orders out of que and sign off on the form. 2. If No Ward clerk is on duty: The Charge nurse will process the order by placing it in PCC, tearing out the original copies, taking the pink copy to the pharmacy or place in pharmacy box and place in the Ward Clerk's inbox.3. When an existing order is changed or clarified, it is to be written in the physician orders and changed in PCC utilizing update. Consult forms are to be treated the same as a telephone or verbal order.

- 3. Always use black ball point pen when writing orders, do not use marker type pens or erasable ink pen.
- 4. Handwriting must be legible.

Revised 02/15

Administration of Medication - (P.I.C.C.) Peripherally Inserted Central Catheter

Note:

Prior to any access of the P.I.C.C. line through the antimicrobial lock cap, an alcohol wipe and friction will be used for 10-15 seconds cleansing the hub prior to this access to adequately cleanse the lock cap. This is not included in each step of the following procedure, but is to be done with each access into the lock cap or port.

Procedure:

STEPS	KEY POINTS
1. Wash hands. Don gloves	1. Reduces transmission of micro-organisms. Standard precautions.
2. Verify physician order for medication.	2. Reduces possibility of medication error.
3. Explain procedure to the patient/family. Outline the reason for the medication.	3. Decreases patient/family anxiety.
4. Open closure clamp on P.I.C.C. extension.	4. There may be a solid extension or a separate clear luer-lock extension tubing present.
5. Flush the P.I.C.C. with 10 ml of normal saline solution.	5. Checks patency of line.
6. Attach the intravenous (I.V.) set for piggyback medication or syringe for I.V. push medication and administer.	6. Inject over the recommended period of time to prevent any untoward effects of too rapid or too slow administration time.
7. Assess the patient during the medication administration as the patient's condition warrants.	7. Assuring there is no adverse reactions
8. After administration, flush with 10ml of NaCl use the "push-pause" technique.	8. The technique creates turbulence within the lumen and assists in the removal of the medication.
9. If TPM, lipids or blood are being discontinued, flush with 20 ml of NaCl.	9. More flush solution is needed to thoroughly clear the lumen of the more viscous solutions.
10. For multiple I.V. push/piggyback medications, or if medications are given with I.V. infusing through the P.I.C.C., flush with 5 ml NaCl between medications and 10 mg at the end of the push/piggyback administration.	10. Prevents possible medication interaction with lumen. Flush with Normal Saline solution at the END of the multiple injections
11. Discard syringes and access cannulas in appropriate sharps disposal container.	11. Standard precautions.
12. Wash hands.	12. Prevents transmission of micro-organisms.
13. Document medication administration and flush solutions in patient's medication administration record (MAR).	13. Documents completion of order. Serves as a legal document. Notes patient response and outcome.

Note: If multiple lines utilize one (1) NaCl flush syringe PER LINE to minimize cross contamination between lines. Do not reuse any flush (ie, before and after administration requires two (2) separate flushes).

Revised 02/15, 04/19

IX HOSPICE

COORDINATION OF HOSPICE SERVICES

Purpose:

To ensure residents receiving Hospice services receive coordinated care that provides the highest quality care and services possible in accordance with the resident's wishes.

The facility will coordinate and provide care in cooperation with Hospice staff for all residents that have elected the Hospice benefit.

Procedure:

1. The facility and Hospice will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to extent possible.
2. The plan of care will identify the care and service that each entity will provide in order to meet the needs of the resident and his/her expressed desire for Hospice care.
3. The facility will communicate with Hospice and identify, communicate, follow and document all interventions put into place by Hospice and the facility.
4. The facility will monitor and evaluate the resident's response to the Hospice care plans.
5. The facility will maintain communication with Hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities.
6. The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary.
7. The facility will monitor for medications and medical supplies to ensure they are provided by Hospice as needed for palliation and management of the terminal illness.
8. All residents receiving hospice will receive the same facility services as residents who have not elected Hospice.
9. The facility will immediately contact and communicate with the Hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations.

07/18

Compliance Guidelines:

The facility will have a written agreement with the Hospice provider that specifies the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.

Treatment:

1. If the resident/sponsor chooses Hospice, their choices will be upheld by the facility when appropriate.
2. The interdisciplinary team and the resident/sponsor will collaborate to arrive at pertinent, realistic and measurable goals for treatment.
3. Factors influencing the choice of treatments include:
 - a. The patient's underlying diagnoses or conditions.
 - b. The causes, location, nature and severity of the diagnosis or conditions.
 - c. The patient's preferences expressed either directly or in an advance directive.
 - d. Possible adverse effects.
 - e. Pain management.
 - f. Other symptoms such as uncontrolled nausea, constipation or vomiting.
 - g. Psychosocial and emotional needs of resident and/or family.
 - h. Spiritual needs.
4. Promote a comforting environment.

END-OF-LIFE CARE

It is our intent to provide quality end-of-life care to a resident per their request, in accordance with his/her advance directives, through discussion with the resident and/or his/her legal representative, and in compliance with state and federal rules and regulations. The facility will strive to ensure pain and symptom management and nutritional and psychosocial care until end-of-life.

- 1) To implement end-of-life care:
 - a. Ensure documentation is present that the resident has approached the end of life.
 - b. Discuss with the resident and/or legal representative the resident's options for care and treatment.
 - c. Ensure documentation is present regarding the resident's advance directives and preferences related to care and treatment at end-of-life.
 - d. Ensure documentation is present related to communication between the resident's physician and the resident and/or his/her legal representative regarding the resident's condition and response to interventions.

- e. Identify barriers to providing effective end-of-life services and adjusting care/services as indicated.
 - f. Ensure staff is aware of the resident's goals and treatment.
 - g. Develop a comprehensive care plan that addresses the resident's choices, rights, and goals.
- 2) The following orders/interventions/services should be considered when implementing end-of-life care:
- a. Physician order for end-of-life care (need orders written for exact dosaging – no ranges)
 - b. Discontinue:
 - i. Routine vitals – (may check at family request if fever evident)
 - ii. Pulse oximeter checks
 - iii. Daily weights
 - iv. Intake & output
 - v. Compression socks
 - vi. Glucose monitoring
 - vii. Physical therapy
 - viii. Occupational therapy
 - ix. Speech therapy
 - c. Laboratory Tests:
 - i. Discontinue lab tests
 - d. Oxygen PRN for air hunger, decreased saturation
 - e. Medications for Pain or Dyspnea Management for opioid naïve patient:
 - i. Dilaudid 1-4mg PO every 3 hours PRN
 - ii. Morphine sulfate 20 mg/ml for sublingual pain (comfort care)
 - 1. 0.5 ml (10mg) every 4 hours PRN pain scale 1-3
 - 2. 0.5 ml (10mg) every 2 hours PRN pain scale 4-6
 - 3. 0.5 ml (10mg) every 1 hour PRN pain scale 7-10
 - iii. Oxycodone 5-10mg PO every 2 hours PRN
 - iv. Oxycontin 10 mg PO every 12 hours (may give rectal if unable to take PO)
 - v. MS Contin 15mg every 12 hours (may give rectal if unable to take PO)
 - vi. Fentanyl/Duragesic patch or similar 12 mcg/hr every 72 hours
 - f. Anti pyretic / Pain:
 - i. Acetaminophen (Tylenol) 650mg PO Q4H, PRN pain or temp greater than 100.4 deg. F
 - ii. Acetaminophen (Tylenol) 650mg PR (Rectal) Q6H, PRN temp greater than 100 deg. F or mild discomfort
 - g. Anxiety, Nausea, Agitation:
 - i. Lorazepam (Ativan) 0.5 – 1mg PO or Sublingually Q4H PRN anxiety, seizures (avoid if delirium present)

- ii. Prochlorperazine (Compazine) 10mg PO or 25mg PR Q6H PRN nausea/vomiting
 - iii. Promethazine 12.5 mg PO every 4 hours PRN nausea
 - iv. Zofran 8 mg PO every 6 hours PRN nausea
 - v. Haloperidol (Haldol) 0.5 – 1mg PO/PRN for agitation Q4H. Call physician if agitation not relieved at these doses
 - h. Bowel Medications:
 - i. Bisacodyl Suppository (Dulcolax) 10mg PR (Rectal) x 1 IF no bowel movement in 72 hrs. give only after rectal check for impacted stool
 - ii. Senokot-S (Senna/Docusate) 1 tablet PO BID
 - i. Secretions:
 - i. Hysocyamine 0.125-0.25mg P/SL every 4-6 hours PRN
 - ii. Transdermal scopolamine patch apply 1-3 patches topically every 3 days PRN
 - iii. Atropine drops 1% 1-2 drops PO/SL every 4-6 hours PRN
 - j. Lubricants
 - i. Artificial tears (Isopto Tears) to both eyes Q shift PRN dryness
 - ii. Saliva substitute (Xero-Lube) 1-3mL PO Q shift PRN dryness
 - i. Water based lubricant to lips Q shift PRN dryness
- 3) Services:
- a. Provide supportive/assistive devices e.g. oxygen, air bed, cushions, pillows, wound care, etc.
 - b. Provide, as possible, resident with private room and/or room for family to stay with resident as much as possible.
 - c. Assess resident's physical, cognitive, and functional status to effectively manage symptoms and provide any remedies for causes of symptoms that would improve prognosis or optimize comfort.
 - d. Provide staff to ensure the needs, desires, and goals of the resident are met.
- 4) Care Plan: (suggested interventions – need to be specific to the resident)
- a. Assist resident in resolving any psychological, emotional, spiritual, and environmental issues that may affect comfort levels.
 - b. Ensure physician reviews and update resident's prognosis with the resident and/or legal representative.
 - c. Review resident goals for care and treatment with resident and/or legal representative.
 - d. Assess resident on a regular basis about his/her pain.
 - e. Adjust the lighting in the resident's room per preference.
 - f. Reduce noise to the extent possible.
 - g. Allow family to stay with resident as desired.
 - h. Ensure ADL's are completed as much as possible depending on tolerance and desires.
 - i. Ensure personal hygiene, include frequent oral care is provided.

- j. Check resident at frequent intervals (e.g. q 1-2 hours).
- k. Provide resident with appropriate equipment (be specific).
- l. Manage my symptoms as much as possible (be specific).
- m. Weight loss is anticipated, however, ensure the desires of the resident and/or legal representative are followed and food and/or fluids offered as desired.
- n. Activities will be conducted only as desired and appropriate.
- o. Routine medications will be reviewed by the physician and discontinued/changed as appropriate.
- p. Pain and other symptom assessment Q4H while awake. Call physician for unrelieved pain or other symptoms.
- q. Oral Hygiene Q2-4 hours PRN.
- r. Fan available at bedside if patient is experiencing dyspnea.
- s. Diet as tolerated.
- t. Turn – Reposition Q4 hours and PRN comfort. Consider pre-medication.

6/26/2018, revised 6/3/19

POSTMORTEM PROTOCOL

In the event of a death of a resident the unit licensed nurse or his/her designee shall:

1. Immediately notify physician/provider for permission to release body/other instructions. (Document discussion in nurse progress notes.)
2. Immediately notify family and/or responsible party as delineated in face sheet of medical record. (Document discussion in nurse progress notes.)
3. Notify mortuary identified in resident's record. (Document discussion in nurse progress notes.)
4. If the resident's death was UNEXPECTED immediately notify:
 - Director of Nursing Services
 - RN Manager
 - Social Services Director
 - Administrator
5. The Ward Clerk shall notify the above parties via e-mail notification (or shortly after arrival to work — if death did not occur during normal business hours).

POSTMORTEM CHARTING PROTOCOL

Include the following in your postmortem charting:

1. Condition of patient when last seen alive (if applicable).
2. Condition of patient when found.
3. Checks made to determine death.

4. (i.e. Apical Pulse for 1 minute, respirations for 1 minute, blood pressure, corneal reflex, pupil size and reaction.)
5. Physical appearance.
 - Rationale for CPR if code status is not marked (i.e. color waxen, cyanotic, mottled, skin temperature, rigor status, restate pupil status).
 - If back-up nurse was called to confirm status, list those notified.
6. Complete mortician's receipt on back of face sheet.
 - Disposition of resident's belongings - valuables if pertinent, when body released, by whom, and to whom, signature to include name and title.
7. Fill out inventory sheet and valuables. Make sure personal belongings are boxed and sent to storage for safekeeping. Check locked drawers. Send all valuables to the Business Office.

NURSE AIDE POSTMORTEM CARE

1. Report to licensed nurse by call system or in person.
2. Stay with nurse and resident.
3. Help with CPR if initiated.
4. If resident is determined to have died, move to private area.
2. Remove all tubes, IV, and foley as directed by nurse.
3. Wash body if soiled. Handle gently to prevent tissue trauma.
4. Place pad under resident.
5. Dress resident in gown open in the back.
6. Arrange in sleeping position.
7. Determine if teeth and glasses should be sent with the resident. If so, place on bed.
8. Cover with clean blanket or sheet as if asleep, do not cover face.
9. If family present, allow for them to take personal items they would like and document what is taken and by whom. Close room and do not remove anything additional. Social Services and/or DNS will take care of personal items left in room.
10. Assist with mortician as requested to transfer body to gurney.
11. If other residents ask if someone has died, you may answer with a simple correct response such as "Yes, John has just died." Give no other personal or medical details.

Revised 7/18

X INFECTION PREVENTION AND CONTROL

INFECTION PREVENTION AND CONTROL COMMITTEE

Infection and contagious disease control will be monitored by the Infection Prevention and Control Committee at the Idaho State Veterans Home. This committee consists of the following staff members:

- Infection Preventionist (Chair)
- Medical Director
- DNS

- Administrator
- Pharmacist
- Dietary Services Supervisor
- Housekeeping (management represent)
- Maintenance Supervisor
- SCD

This committee will be responsible for the development and implementation of infection prevention and control policies and procedure. This committee will meet as a group no less often than quarterly to review areas of concern. Identified trends/problems, outbreaks of influenza, diarrhea or other contagious processes will be monitored and/or investigated by this committee. If problems arise, an emergency meeting may be called at any time.

This meeting is also for the purpose of dissemination of information to ancillary departments and coordination of efforts. Areas of infection control, safety and sanitation, and pest control will also be discussed. Wellness programs and preventative safety precautions may be agenda items.

A review of current policies and procedures will take place as needed but no less than annually.

Revised 11/18

INFECTION PREVENTIONIST

Purpose:

To establish and maintain an infection control and prevention program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections.

Procedure:

1. The facility will designate a qualified individual (professional licensed nurse or certified professional who is certified in infection control and prevention services) as Infection Preventionist (IP) (individual or individuals designated by the facility to be responsible for the infection prevention and control program.
2. The infection preventionist is adequately qualified and meets eligibility requirements:
 - a. Current licensure in nursing in the state of Idaho.
 - b. Primary professional training in nursing, medical terminology, microbiology and epidemiology.
 - c. Education, training, experience or certification in infection control and prevention.
 - d. Completed specialized training in infection prevention and control through accredited continuing education.
 - e. Works at least part-time in the facility.
3. The infection preventionist works directly with the director of nursing, providers, pharmacy and administrator.
4. The responsibilities of the IP or designee include but are not limited to:
 - a. Developing and implementation of an ongoing infection prevention and control program to recognize, prevent and control the onset and spread of infections.
 - b. Establish facility wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff and visitors.
 - c. Develop and implement written procedures in accordance with CMS standards of practice and recognize guidelines for infection prevention and control.
 - d. Develop and implement ongoing antibiotic stewardship program.
 - e. Audit resident care activities (use and care of urinary catheters, wound care, incontinence care, high risk procedures, hand hygiene, etc.)
 - f. Review and/or revise the facility's infection prevention and control program, it's standards, and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with the current standard of practice for preventing and controlling infections.
5. The IP or designee will participate on the quality assurance (QA) committee and will report regularly on the infection prevention and control program activities.

Revised 03/18, 11/18, 5/2019

EMERGING DISEASES PROCEDURE

Purpose:

Emerging infectious disease, diseases including pandemic influenza, and COVID-19 have been identified as a specific hazard that could disrupt the operations of the long-term community. It is the intent of this policy to protect residents, families and staff from harm resulting from exposure to an emergent infections disease, and to provide systems and resources both within the community and the Idaho State Veterans Home, to maintain essential functions during a pandemic.

At the Idaho State Veterans Home-Pocatello, we are at an increased risk of exposure to pathogens from the community related to the many volunteers who participate in our Activity program, and the students who study with us as part of their Nursing education. As part of the volunteer and student orientation we provide general education about pathogen transmission, hand hygiene and cough etiquette. During community and or facility outbreaks we will post additional education at the entrance alerting all to the presence of a greater influx of influenza as well as requesting to avoid our facility if they are experiencing any illness.

1. General Preparedness for Emergent Infectious Diseases (EID)
 - a. Idaho State Veterans Home's emergency operation program will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza. This plan will:
 - i. Build on the workplace practices described in the infection prevention and control policies
 - ii. Include administrative controls (screening, isolation, visitor policies and employee absentee plans)
 - iii. Address environmental controls (isolation rooms, plastic meal services, sanitation stations and special areas for contaminated wastes)
 - iv. Address human resource issues such as employee leave
 - v. Be compatible with the State of Idaho Division of Veterans Services Continuity of Operations Plan.
 - b. Members of the EID planning committee will include but is not limited to:
 - i. Administrator or designee
 - ii. Medical director
 - iii. DNS or designee
 - iv. Nurse Manager
 - v. IP Nurse or designee
 - vi. Housekeeping
 - vii. Maintenance services
 - viii. Pharmacy consult
 - c. Clinical leadership will be vigilant and stay informed about EIDs around the world. IP nurse or designee will monitor facility infections and media for community infections and facilitate relationships with partner labs and the department of health and welfare epidemiologist. IP nurse and designee will also

register with health alert network (HAN) at the department of health and welfare to receive community alerts.

- d. As part of the emergency operations plan, the facility will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, foot and head coverings, face masks, **assorted sizes of disposable N95 respirators**, and gloves. The amount that is stockpiled will minimally be enough for several days of home-wide care but will be determined based on storage space and cost.
- e. The facility will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption of normal business including an EID outbreak.
- f. The facility will regularly train employees and practice the EID response plan through drills and exercises as part of the center's emergency preparedness training.

2. Local Threat

- a. Once notified by the public health authorities at either the federal, state and/or local level that the EID is likely to or already has spread to the community, the facility will activate specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and /or the local public health authorities.
- b. The facility's IP or designee will research the specific signs, symptoms, incubation period, and route of infections, the risks of exposure and the recommendations for skilled nursing care centers as provided by the CDC, Occupation Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.
- c. Working with advice from the facility's EID planning committee, local and state public health authorities, and others as appropriate, the IP or designee will review and revise internal policies and procedures, stock up on environmental cleaning agents, and PPE as indicated by the specific disease threat.
- d. Staff and contractors will be educated on the exposure risks, symptoms, and prevention of the EID. Special emphasis will be placed on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention strategies such as hand hygiene.
- e. If EID is spreading through an airborne route, then the facility will activate its respiratory protection plan.
- f. Residents and families will be educated about the disease and the facility's response strategy at a level appropriate to the interests and need for information.
- g. Signs regarding hand hygiene and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who suspects they are ill must not enter the building.
- h. To ensure that staff, volunteers, visitors, and/or new residents are not at risk of spreading the EID into the facility, screening for exposure risks and signs and symptoms may be performed.

- i. Self-screening: Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
 - i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
 - ii. Precautionary removal of employees who report an actual or suspected exposure to the EID.
 - iii. Self-screening for symptoms prior to reporting to work.
 - iv. Prohibiting staff from reporting to work if they are sick until cleared to do so.
 - j. Self-isolating: in the event there are confirmed cases of the EID in the local community, the facility may consider ceasing all admissions, and limiting visitors based on the advice of local public health authorities.
 - k. Environmental cleaning: the facility will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.
 - l. Engineering controls: the facility will utilize appropriate physical plan alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations and special areas for contaminated wastes as recommended by local, state and federal public health authorities.
3. Suspected care in the home
- a. Place a resident who exhibits symptoms of the EID in an isolation room and notify local public health authorities.
 - b. Under the guidance of the public health authorities, transfer of suspected infectious person to the appropriate acute care center will occur.
 - c. If the suspected infectious person requires care and transport, follow care center policies and CDC recommendations for isolation procedures, including all recommended PPE for staff at risk of exposure.
 - d. Keep the number of staffs assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated) will enter the isolation room.
 - e. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individual, and monitoring for additional cases under the guidance of the local health authorities, and in keeping with guidance from the CDC.
 - f. Implement the isolation protocol in the facility (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the facility's infection prevention and control plan and/or recommended by local, state, or federal public health authorities and in keeping with CDC recommendations.
 - g. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities and in keeping with guidance from the CDC.
4. Employer Considerations

- a. Management will consider its requirements under OSHA, Center for Medicare and Medicaid (CMS), state licensure, and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and employees shall be of paramount concern. Management will consider the following:
 - i. The degree of frailty of the residents in the home;
 - ii. The likelihood of the infectious disease being transmitted to the residents and employees;
 - iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated surfaces)
 - iv. The precautions which can be taken to prevent the spread of the infectious disease and
 - v. Other relevant factors
- b. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.
- c. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
- d. Generally, accepted scientific procedures, whenever available, will be used to determine the level of risk posed to and/or by an employee.
- e. Permit employees to use sick leave, vacation time and FMLA while they are out of work as applicable.
- f. Permit employees to return to work as applicable however, additional precautions may be taken to protect the residents.

References:

- i. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities*. (March 2019 Revision) *Emergency Preparedness* 483.73.
- j. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- k. OSHA *pandemic guidelines* https://www.osha.gov/Publications/influenza_pandemic.html
- l. CDC- *Pandemic Influenza* (link: <https://www.cdc.gov/flu/pandemic-resources/index.htm>)
- m. CDC- *Pandemic Influenza Plan- 2017 Update* (<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>)
- n. CDC- <https://www.cdc.gov/mmwr/PDF/rr/rr4305.pdf>
- o. CDC- *Long-Term Care and other Residential Facilities Pandemic Influenza Planning Checklist* (<https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>)
- p. CDC- *NIOSH Approved Particulate Filtering Piece Piece Respirators* (December 6, 2018) https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html

- q. CDC- *Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response* (March 5, 2020)
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html>

3/2020, 4/6/2020

PERSONAL PROTECTIVE EQUIPMENT PROCEDURE

Purpose:

Personal protective equipment (PPE) procedure is created to establish procedures for controlling exposure to infectious pathogens, limiting outbreaks in the Home and protect staff from infectious pathogens.

Personal protective equipment or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, eyes, skin and clothing from contact with pathogens. It includes but is not limited to gloves, gowns, facemasks, goggles, face shields and respiratory protection (surgical masks/respirators/rebreathers).

Procedure for Personal Protective Equipment (PPE):

All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids or potentially infectious materials is likely.

1. ISVH-P uses standard precautions for all residents regardless of suspected or confirmed diagnosis.
2. This practice includes the following:
 - a. Gloves are used when direct contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment is anticipated.
 - b. Gowns are used as a barrier for arms, exposed both areas and keep clothing from contamination with blood, body fluids and other potentially infectious material.
 - c. Goggles/face shields are used there is potential for splashes, sprays or uncontrolled sneezes/coughs.
 - d. Respiratory protection will be used depending on the transmission route of the pathogen. Surgical masks are worn for droplet transmitted pathogens and respirators/rebreathers are worn for airborne transmitted pathogens.
3. This practice also includes risk assessment with use of appropriate personal protective equipment (PPE) such as gloves, gowns and face masks/respirators based on the activity being performed, residents' ability to practice cough etiquette and suspected or diagnosed pathogens.

Donning PPE:

1. **Perform hand hygiene using hand sanitizer.**
2. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel.
3. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a **facemask if a respirator is not available**). If the respirator has a nosepiece, it should be fitted to the

nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under the chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.

- a. **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - i. Positive pressure seal check:
 1. Don clean non-sterile gloves
 2. Apply rebreather
 3. Exhale gently while blocking the paths for air to exit
 4. During a successful check, the facepiece is slightly pressurized before increased pressure causes outward leakage
 - ii. Negative Pressure user seal check:
 1. With clean non-sterile gloves still in place
 2. Inhale sharply while blocking the paths for air to enter the facepiece.
 3. During a successful check the facepiece will either collapse slightly or pull tight to face under the negative pressure.
 4. Doff gloves and perform hand hygiene
4. **Put on face shield or goggles.** Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
5. **Perform hand hygiene before putting on gloves.** Gloves should cover the cuff (wrist) of gown.
6. **Healthcare personnel may now enter patient room.**

Doffing PPE:

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak)
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.
3. **Healthcare personnel may now exit patient room.**
4. **Perform hand hygiene**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).** Do not touch the front of the respirator or facemask.
 - a. **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.

Donning for extended or reuse/redonning PPE:

1. Perform hand hygiene
2. Apply gown
3. Apply N-95 rebreather pinching the adjustable nose clip for a tight fit, must wear gloves
4. Perform User Seal Checks. To avoid self-inoculation hand hygiene and donning/doffing gloves must be used for this procedure.
 - a. Positive Pressure Check:
 - i. Don clean non-sterile gloves
 - ii. Apply rebreather
 - iii. Exhale gently while blocking the paths for air to exit
 - iv. During successful check the facepiece is slightly pressurized before increased pressure causes outward leakage.
 - b. Negative pressure user seal check:
 - i. With clean non-sterile gloves still in place
 - ii. Inhale sharply while blocking the paths for air to enter the facepiece.
 - iii. During a successful check the facepiece will either collapse slightly or pull tight to face under the negative pressure.
 - iv. Doff gloves and perform hand hygiene.
 - c. Apply eye protection
 - d. Apply hair cover
 - e. Apply shoe covers (if preferred)
 - f. Perform hand hygiene and apply clean non-sterile gloves

Doffing for extended or reuse/redoffing PPE:

1. Remove gloves and gown
2. Perform hand hygiene
3. Don clean gloves
4. Remove hair cover
5. Remove eye protection, disinfect with wipes
6. Remove N-95 rebreather, follow disinfection procedure
7. Remove shoe covers (if worn)
8. Doff gloves
9. Perform hand hygiene

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880-Infection Prevention and Control. 42 C.F.R. 483.80(a)(2)(e)
- b. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>

- c. Centers for Disease Control and Prevention. *Standard Precautions for all Patient Care* (Reviewed January 26, 2016). <https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>
Developed 5/2020

TUBERCULOSIS CONTROL PLAN

Employees

All new employees shall be screened for presence of infection with M. Tuberculosis using the PPD skin test. This facility is considered low risk (CDC: May 17, 2019) and employees will be followed if s/s or exposure.

1. All employees shall be screened within 30 days of hire regarding the presence or absence of symptoms consistent with tuberculosis such as:
 - a. Productive cough greater than 3 weeks;
 - b. Fever/night sweats;
 - c. Loss of appetite;
 - d. Coughing up blood;
 - e. Fatigue/weakness;
 - f. Unexplained weight loss.
2. Employees with a negative PPD skin test history shall obtain a PPD skin test within thirty days of employment (or present proof of negative PPD status within the last year).
 - a. Employees in need of a current (within one year) PPD skin test shall utilize the form in their orientation packet.
 - b. Employees may obtain the PPD skin test from the Infection Control Preventionist or a licensed nurse.
 - c. Employees obtaining the PPD skin test must have the test read by a licensed nurse and results documented on the appropriate form 48-72 hours after testing.
 - d. Employees will then submit the completed form to the facility's Infection Control Preventionist or designated representative for tracking and follow-up, as needed.
3. For purposes of interpretation, a skin test reaction of > 10mm. induration is generally considered positive.
 - a. A person with a positive PPD (> 10 mm.) shall be referred either to their private physician or to the Public Health Department for follow-up and/or treatment.
 - b. A letter from a physician or health department attesting to the non-infectious nature of the employee and must be received within one week of positive PPD result.
4. Employees with a documented history of a positive PPD will not undergo skin testing. Employees will, however, complete the Tuberculosis Assessment form and return to the facility's Infection Control Nurse or designated representative for further processing.
5. Employees who are medically exempt from receiving a PPD skin test (e.g. pregnancy) must submit a letter to the Human Resource Department from a physician attesting to the

exempt status. When/if the medical condition allows testing, the above procedure shall be instituted.

Residents - Tuberculosis

1. Residents shall be screened for infection with M. Tuberculosis on admission.
 - a) PPD testing shall consist of a Mantoux skin test injected intracutaneously.
 - b) Residents with a history of a positive skin test shall be screened by a chest x-ray and a physician's clinical assessment documented in the admission progress notes.
 - c) Skin testing for new admissions will employ the two-step procedure.

Note: Residents who readmit to ISVH-P after an acute hospitalization or a stay at another facility for a period greater than 72 hours but not more than 30 days, and who are known to have a prior negative two step test; will be exempt from the two step skin test process and will be screened for infection using a one-step skin test.

- i. If the reaction to the initial PPD test is < 10 mm, a second test will be given 7-14 days later.
 - 1) A positive second test is indicative of a boosted reaction and NOT a new infection.
 - 2) If the second test remains negative, the person is classified as uninfected.
 - ii. For purposes of interpretation, a skin test reaction of > 10 mm. induration is generally considered positive.
2. The results of all skin tests will be documented on the resident's immunization sheet located in PCC and positive test results will be reported to the resident's physician for further follow-up.
3. All skin-test positive residents shall be evaluated on an annual basis regarding the presence or absence of symptoms consistent with tuberculosis such as:
 - a) Productive cough greater than 3 weeks;
 - b) Fever/night sweats;
 - c) Loss of appetite;
 - d) Coughing up blood;
 - e) Fatigue/weakness
 - f) Unexplained weight loss.
4. Individuals with diagnosed tuberculosis will be admitted to the facility only after effective therapy has been initiated and the patient is no longer deemed infectious.

References:

- d. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 21017 Revision) F880 – Infection Prevention and Control. 42 C.F.R. 483.80 (a)
- e. Sigel JD, Rhinehart E, Jackson M, Chiarello L, and the ealthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>

- f. Centers for Disease Control, *MMWR May 17, 2019: Tuberculosis Screening, Testing and Tuberculosis Controllers Association and CDC, 2019*,
https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w
- g. Centers for Disease Control, *MMWR June 09, 2000: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection*,
<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm>

Reviewed 08/15, 11/18, 01/19, Revised 8/19

TUBERCULOSIS EXPOSURE INCIDENT

In the event of documented exposure to a diagnosed case of pulmonary tuberculosis, all exposed employees and residents will undergo the following:

1. PPD skin test, if previous PPD negative.
2. Follow-up PPD skin test in 10-12 weeks.
3. If results of the test is positive:
 - a. chest x-ray will be obtained.
4. All new PPD converters, regardless of the chest x-ray results, will be referred to their private/facility physician for continued follow-up.
 - a) Employees who convert may resume their employment contingent upon the receipt of documentation attesting to lack of infectious process.
 - b) Residents who convert shall be evaluated by the resident's physician for active tuberculosis.
5. The facility is not equipped with negative pressure isolation rooms and will neither admit nor provide care for any resident suspected or known to have active pulmonary tuberculosis.
6. Any such resident shall be immediately discharged.
7. Residents requiring transport while considered infectious with tuberculosis shall be provided with a standard surgical mask for the containment of respiratory secretions.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- b. CDC, *Infection Control (Injection Safety)*. (Updated March 2, 2011).
<https://www.cdc.gov/injectionsafety/providers.html>.
- c. CDC, *Tuberculosis (TB)*. (Updated December 3, 2018). <https://www.cdc.gov/tb/>.
- d. CDC, *Tuberculosis (TB) Guidelines*. (Updated January 5, 2018).
<https://www.cdc.gov/tb/publications/guidelines/default.htm>.
- e. CDC/NIOSH, *Tuberculosis*. (March 17, 2016). <https://www.cdc.gov/niosh/topics/tb/>.
- f.

Reviewed 01/15, 11/18, 4/20

TUBERCULOSIS (PPD) TESTING – EMPLOYEE / VOLUNTEER

Name _____

All employees/volunteers will be screened for presence of infection with M. Tuberculosis within thirty days of employment.

Please indicate one of the following:

- I have had a PPD test within the last year. The results of the test were negative. Attached is a copy of those results.
- I have a documented history of a positive PPD. Attached is a copy of a letter from my physician or public health department attesting to the non-infectious nature of my positive reading. (Must be dated within the last year.) (Refer to tuberculosis assessment.)
- I have a negative PPD skin test history (or am unsure of my PPD status) and need to receive a PPD test. Refer to the steps below.
- It is your responsibility to go to the nursing unit for which you are assigned to receive your PPD skin test within thirty working days. (If you are employed in another department please obtain the test and have the results read by a licensed nurse.)
 - It is your responsibility to have the skin test read approximately 48 - 72 hours following administration of the PPD. Be sure you will be at work within this window of time.
 - It is your responsibility to submit this completed form to the Infection Preventionist or Human Resource Department immediately following completion.
 - If the results of the skin test are positive (induration of > 10 mm. in size) it is your responsibility to seek medical care per your personal physician or the public health department regarding your infectious status.
 - If the skin test is positive you must obtain a letter stating your non-infectious status before returning to work.

I give my permission to have a Tuberculosis test done.

Employee/volunteer signature

Date

Date tested

Site tested

Nurse Signature

Date read

Results (Size of induration in mm.)

Nurse signature



Employee Name: _____

Date of last PPD: _____

The above person received a PPD test:

Nurse administering test Site Date/Time

Lot # Expiration Date

Test was found to be: ____Positive ____Negative

Nurse reading results Date / Time Size of induration (mm)

*** Document size of induration whether test is positive or negative ***

Date of chest x-ray if positive PPD: _____

Please return completed form to RN Manager or Infectin Preventionist / SDC. Thank you.

Tuberculosis Assessment

(For use with staff who are PPD positive or medically exempt upon hire and annually thereafter)

Please complete the following brief questionnaire about your health:

Do you currently have any of the following symptoms?

- 1. Cough lasting greater than 2 weeks? ___yes ___no
- 2. Unexplained weight loss? ___yes ___no
- 3. Loss of appetite? ___yes ___no
- 4. Unexplained fever? ___yes ___no
- 5. Night sweats? ___yes ___no
- 6. Blood tinged sputum production? ___yes ___no

If yes to any question, please describe symptoms further. When did this start? Have you sought treatment? If yes, what treatment was done?

Employee signature

Date

Infection Preventionist

Date

FOR OFFICE USE ONLY

Was this employee referred for further evaluation? ___ yes ___ no

If yes, to whom?

Chest x-ray? _____ Medication? _____ Work restrictions? _____

Infection Preventionist

Date

Revised 11/18

HEPATITIS B IMMUNIZATION PROGRAM

Purpose:

To establish guidelines for employee screening for Hepatitis B immunity and vaccine administration.

1. Employees who perform tasks requiring exposure to blood and other potentially infectious materials per exposure determination will be offered the Hepatitis B Vaccine free of cost.
2. Following a review of the disease and vaccine information, the employee will sign a consent to receive the vaccine. (See “Information on Hepatitis B and the Vaccine.”)
3. If an employee declines immunization, he/she will sign a waiver. If the employee chooses to be immunized in the future, this procedure will be followed.
4. Three IM doses of vaccine will be given - the initial dose, at one month and at six months. The vaccine will be administered deep intra-muscular in the deltoid muscle.

Reviewed 11/18

INFORMATION ON HEPATITIS B AND THE VACCINE THE DISEASE

The Disease

Hepatitis B is a viral infection that affects the liver. The incubation period ranges from 40 to 180 days. The course of acute hepatitis can be mild and completely without outward symptoms, or it can be severe, prolonged, and possible fatal. Health care workers can be exposed to Hepatitis B from contaminated needle punctures or blood spills on broken skin or mucous membranes. Other body fluids, such as bloody urine, bloody wound drainage, or semen, may also be infectious. The greatest threat to health care workers is the nearly one million Hepatitis B carriers in the country, 80 to 90 percent of whom are not identified.

Recombinant Hepatitis B Vaccine

The vaccine is for protection against Hepatitis B. The vaccine is recommended for those with frequent exposure to the above sources. Three doses of vaccine are required: The initial dose, a second dose a month later and a third dose five months later. A booster dose may be needed at a later time for continued protection. Documentation of exposure incidents must continue even after the vaccine series is completed.

Hepatitis B vaccine will not prevent hepatitis caused by other agents, such as Hepatitis A virus, non-A, non-B Hepatitis virus or by other viruses known to infect the Liver. Although information available to date indicates that the vaccine is highly effective in protecting against Hepatitis B, it has not proven totally effective in preventing Hepatitis B among all persons vaccinated (those who are immune-suppressed or those with presence of any serious active infection). Hepatitis B vaccine is prepared from recombinant yeast cultures and is free of association with human blood or blood products.

Follow-up studies indicate that the most common side effect is injection site soreness. Less common local reactions are redness, swelling, and warmth, which usually subside within 48 hours. Low-grade fever occurs occasionally. Other complaints include malaise, fatigue, headache, nausea, dizziness and joint pain. These symptoms are infrequent and limited to the first few days following the vaccine. Rash has been reported rarely.

Precautions

Recombinant Hepatitis B Vaccine is contraindicated for individuals who are hypersensitive to yeast or any component of the vaccine. Any serious active infection prior to receipt of the vaccine is reason to delay the vaccine.

Employees with a history of cardiopulmonary disease are at risk from a possible febrile or systemic reaction and must consult their private physicians prior to receipt of the vaccine, and have an authorization from their private physician for administration of the vaccine.

HEPATITIS B VACCINATION OFFER

I understand that I am offered the HBV vaccine at no charge to myself and will obtain the series of vaccines at the nursing station where I am assigned.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring Hepatitis B virus (HBV) infection. I am offered the opportunity to be vaccinated against HBV at no charge, however, I decline the HBV vaccination at this time.

I understand that by declining this vaccine, I continue to be risk for acquiring HBV. If in the future I continue to have occupational exposure and I want to be vaccinated with HBV vaccine, I can receive the series at no charge.

I understand I am offered the HBV vaccine at no charge to myself, however I decline due to the fact that I have received the series at another facility.

I understand that if I received a partial series, I may finish the series at no charge.

Employee Signature	Date	Employee's SSN
<u>Hepatitis B Vaccination Tracking</u>		
Dose #1 Date _____	Nurse Signature _____	
Dose #2 Date _____	Nurse Signature _____	
(1 month later)		
Dose # Date _____	Nurse Signature _____	
(6 months later)		

Reviewed 11/18

Information on Hepatitis B and the Vaccine can be obtained from the Infection Preventionist



Employee Name: _____

Date of Employment _____

HEPATITIS B VACCINE

I _____ (do/do not) want to receive the Hepatitis B Vaccine that Idaho State Veterans home – Pocatello is offering to me.

Reason: _____

I fully understand the purpose of the vaccine and am aware that it will protect me from the Hepatitis B organisms that may be found in body fluids. I also understand that the series of 3 injections (\$150.00 value) is offered to me at no cost.

Signature

Date

The above person has received the Hepatitis B Vaccine as follows:

HANDLING AND/OR DISPOSING OF USED NEEDLES

Purpose:

To provide guidelines for the safe handling and disposal of used needles.

1. Equipment And Supplies
 - a) Sharps container,
 - b) Gloves (as indicated); and
 - c) Other as necessary or appropriate.

2. Safety Precautions
 - a) After use, discard the needle without recapping into the sharps container.
 - b) If recapping is absolutely indicated, and the sharps container is not readily available, the cap should be reapplied using one of the following methods before leaving the point of use:
 - i. Use a needle-recapping device (e.g. stationary cap-holding device); or
 - ii. Place the cap on a horizontal surface and use the one-hand scoop method to slide the needle into the cap.
 - c) Used needles must be placed in the sharps container. Do not bend, break, or cut needles. When the sharps container is 75% to 80% filled, the container must be stored until picked up for proper disposal.
 - d) Needles, used or unused, may not be discarded into trash receptacles.
 - e) In the event of a needle stick injury, the employee should:
 - i. **Immediately** wash the wound with soap and running water;
 - ii. Cause the injured site to bleed;
 - iii. If desired, apply alcohol or hydrogen peroxide to the wound;
 - iv. Notify the Infection Preventionist of the incident as soon as practical.
 - f) Refer to procedure “Protocol for Exposure to Blood Borne Pathogens.”

References:

- g. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
 - h. CDC, *Infection Control (Injection Safety)*. (Updated March 2, 2011). <https://www.cdc.gov/injectionsafety/providers.html>.
- CDC/NIOSH, *Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C*. (April 7, 2017). <https://www.cdc.gov/niosh/topics/bbp/disposal.html>

Reviewed 11/18, revised 4/2020

HAND HYGIENE

Purpose:

Hand hygiene is a general term that applies to either handwashing (mechanical cleansing using soap and water) or the use of an antiseptic (alcohol-based) hand rub. Hand hygiene is a simple and effective method for preventing the spread of pathogens, such as bacteria and viruses which cause infections. Pathogens can contaminate the hands of staff through direct contact with residents or contact with contaminated equipment and environmental surfaces within close proximity of the resident. Failure to clean contaminated hands can result in the spread of these pathogens to residents, staff and environmental surfaces.

To protect our residents, visitors and staff, our facility promotes hand hygiene practices during all care activities when working in all location within the facility. All staff, contractors and volunteers and students are expected to follow the hand hygiene policy and visitors are encouraged as well

Procedure:

1. Hand Rub:

- a. Apply a palmful of product to palm of one hand
- b. Cover all surfaces with the product.
- c. Rub hands together, covering all surfaces of hands and fingers, until hands are dry.

2. Hand Washing:

- a. Stand in front of sink, keeping hands and uniform away from sink surface (if hands touch sink during procedure start over).
- b. Turn on water, regulate the flow and temperature, water should be warm.
- c. Avoid splashing water against uniform.
- d. Wet hands and wrists thoroughly under running water.
- e. Keep hands and forearms lower than elbows during washing.
- f. Apply a small amount of soap or antiseptic, lathering thoroughly.
- g. Wash hands using plenty of lather and friction for at least 20 seconds.
- h. Interlace fingers and rub palms and back of hand with circular motion at least 5 times each. Keep fingertips down to facilitate removal of microorganisms.
- i. Areas underlying fingernails are often soiled. Clean them with fingernails of other hand if heavily soiled.
- j. Rinse hands and wrists thoroughly, keeping hands down and elbows up.
- k. Dry hands thoroughly from fingers to wrists and forearms with paper towel.
- l. Turn off water using a clean paper towel.
- m. Discard paper towel.
- n. If hands are dry or chapped may apply a small amount of lotion or barrier cream.

ISVH-P has based its hand hygiene policies/procedures on the research and recommendations of the CDC and WHO. The following are the expected times for performing hand hygiene.

- a. Prior to donning gloves
- b. After doffing gloves
- c. After using the restroom

- d. Prior to eating
- e. After eating
- f. In-between each tray pass
- g. After each medication pass
- h. Prior to and after assisting residents with any personal care.
- i. Prior to and after touching a residents' environment.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control 42 C.F.R. 483.80 (a)(2)(iii) Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) The Hand hygiene procedures to be followed by staff involved in direct resident contact.
- b. CDC, *Hand Hygiene in Healthcare Settings*. (April 29, 2019 Reviewed).
- c. WHO, *FAQs: Hand Hygiene in Health Care*, <https://www.who.int/gpsc/tools/faqs/about/en/>

Revised 02/15, 11/18, Revised 3/2019, 1/2020, 5/2020

USING GLOVES

Purpose:

To provide guidelines for the use of gloves for resident and employee protection.

1. Clean glove procedure:
 - a. Wash hands.
 - b. Don gloves.
 - c. When gloves are indicated, disposable single-use gloves should be worn.
 - d. Used gloves should be discarded into the waste receptacle inside the room.
 - e. Sterile gloves should be used only in performing sterile procedures (e.g. foley insertion).
 - f. Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces.
 - g. Wash hands after removing gloves. Gloves do not replace hand washing.
 - h. Disposable (single-use) gloves must be replaced as soon as practical when contaminated or as soon as feasible if they are torn or punctured and when they exhibit signs of deterioration or when their ability to function as a barrier is compromised.

2. Gloves should be used:

- a. When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin;
 - b. When employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc.;
 - c. When cleaning up spills or splashes of blood on body;
 - d. When handling potentially contaminated items;
 - e. When it is likely that hands will come in contact with blood, body fluids, or other potential infections material;
 - f. When performing phlebotomy or starting an IV.
3. Sterile Glove Procedure:
- a. Wash hands.
 - b. Putting on sterile gloves:
 - i. Obtain gloves. (NOTE: If gowning procedures are used, put gloves on after putting on the gown so that the cuff of the gloves can be pulled over the sleeve of the gown.)
 - ii. Open the package. Being careful not to touch the gloves.
 - iii. With one hand, grasp a glove by the inside of the cuff. Insert opposite hand into the glove. Leave the cuff turned down.
 - iv. Pick up the remaining glove with gloved hand and place fingers under the cuff. (Keep thumb away from glove cuff.) Insert ungloved hand into the second glove.
 - v. Pull up cuffs.
 - c. Removing gloves:
 - i. Grasp glove on palm near the wrist. Carefully pull the glove off.
 - ii. Hold the glove in the palm of the still-gloved hand. Slip 2 fingers under the wrist of the remaining glove.
 - iii. Pull the glove off until it becomes inside out. The 1st glove should end up inside the second glove. Discard the glove safely
 - iv. Always to remember to wash hands/ sanitize after removing gloves.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- b. CDC, *Isolation Precautions*. (Reviewed July 22, 2019). <https://www.cdc.gov/infectioncontrol/guidelines/isolation/>

Revised 4/2020

PROTOCOL FOR EXPOSURE TO BLOOD BORNE PATHOGENS

- 1. A blood borne exposure is an exposure to blood or potentially infectious body fluid through:

- a. Needle stick, puncture or cut by an object through the skin, *or*
 - b. Direct contact of mucous membrane (eyes, mouth, nasal, etc.) *or*
 - c. Exposure of broken skin to blood or other potentially infectious body fluids.
2. Immediate treatment for blood borne exposures:
 - a. Needle-sticks, cuts and akin exposures: Wash with soap and water (Do not use bleach).
 - b. Splashed to the nose, mouth, or skin: Flush with water.
 - c. Splashes to the eyes: Irrigate with sterile irrigates, saline or clean water.
3. All exposures require reporting to the Infections Preventionist and complete an incident / accident report.
 - a. HIV and Hepatitis A, B, And C testing will be done at the time of the stick, and at 3, 6, and 12-month intervals.
 - b. Lab result records will be maintained in the specific employee's medical file.
 - c. Affected employee will be informed regarding recommendations for Hepatitis B prophylaxis.
4. If the resident involved in the needle stick can be identified, then the following shall be implemented:
 - a. Resident will be medically assessed for signs/symptoms of an infectious disease process.
 - b. Length of stay in facility shall be determined.
 - i. If resident has no signs/symptoms of an infectious disease process and has been a resident in the facility for greater than 5 years, no further action will be taken.
 - ii. If resident has been in facility less than 5 years, licensed nursing staff shall:
 1. Obtain order for lab testing for HIV/Hepatitis B.
 2. Notify family/responsible party regarding proposed interventions.

Revised 01/15, 11/18

RECOMMENDATIONS FOR HEPATITIS B PROPHYLAXIS
FOLLOWING PERCUTANEOUS OR PERMUCOSAL EXPOSURE

Exposed Person	HBsAg Positive	HBsAg Negative	Source not tested or unknown
Unvaccinated	HBIG X 1* and initiate HB vaccine series	Initiate HB vaccine series	Initiate HB vaccine series
Vaccinated:			
Known responder	No treatment	No treatment	No treatment
Known non-responder	HBIG X 2 or HBIG X 1 and initiate	No treatment	High risk source may treat as if revaccination.
Vaccinated:			
Response unknown	Test exposed for anti-HB's	No treatment	Test exposed for anti-HB's
	1. If adequate, no treatment.		If adequate, no treatment.
	2. If inadequate, ** HBIG x 1 plus one HB vaccine booster dose.		If inadequate, initiate revaccination series.

Hepatitis B Immune Globulin (0.6 ml/kg IM)

** Adequate anti- HB's is ≥ 10 mIU/ml

Reviewed 4/2020

References:

- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- d. Centers for Disease Control, *Infection Control (Injection Safety)*. (Updated March 2, 2011). <https://www.cdc.gov/injectionsafety/providers.html>.
- e. CDC/NIOSH, *Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C*. (April 7, 2017). <https://www.cdc.gov/niosh/topics/bbp/guidelines.html>

BIOHAZARD SPILL KITS

1. Blood Spill Kits are available in the Treatment Room. Additional kits are available from Housekeeping staff. Each Blood Spill Kit contains specific items needed to comply with OSHA Blood Borne Pathogen Regulations. (i.e. gloves, face mask, isolyser powder, plastic scoop, Bio-hazard disposable bag and instruction sheet.)
2. If a large volume blood spill occurs (nose bleed, GI bleed) obtain a kit from the Treatment Room. Don an apron or disposable gown, an eye shield/face mask and gloves. Sprinkle the isolyser onto blood spill, allow to congeal, 5 to 10 minutes. Use the plastic scoop to pick up the solidified liquid and dispose of properly by placing in the Bio-hazard bag, seal with tie-band and place in the Bio-hazard trash.

Report process to Infection Preventionist or RN Manager.

Revised: 02/15, 11/18

SOILED LINEN HANDLING

Purpose:

Soiled laundry and bedding (e.g. personal clothing, gowns, bedsheets, blankets, towels, etc.) shall be handled in a manner that prevents gross microbial contamination (using standard precautions) of the environment and persons handling the linen.

Procedure:

1. Soiled laundry and bedding contaminated with blood or other body fluids will be handled as little as possible and kept away from the body when handling / transporting.
 - a. Place soiled laundry in a plastic bag at the location where it is used. You may double bag contaminated linen if wet enough to potentially leak or soak through the bag.
 - b. All laundry soiled with blood or suspected to be contaminated with infectious materials must be in sugar bags then placed in a red biohazard bag before placing in the soiled laundry bins.
 - c. Laundry soiled with gross fecal matter, should be rinsed out in the spray tub in the soiled linen room attempting to reduce the gross fecal matter. This wet laundry should then be placed in a plastic bag before placing in the soiled laundry bins.
 - d. Place and transport soiled laundry in bags or containers to the soiled utility room where the bagged soiled linen will be placed into the large soiled linen bin.
 - e. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g. gowns if soiling of clothing is likely).
 - f. Linen that is likely contaminated with potentially infectious materials will be placed in sugar bags then in a red biohazard bag and staff will manage this laundry following the transmission based precaution procedure.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Handling Laundry/Transport of Laundry Program. 42 C. F. R. 483.80 (e).
- b. HealthCare Laundry Accreditation Council. (2015). *Checklist: Accreditation Standards 2016 edition*. Accessed on January 30, 2020 from <https://www.infectioncontroltoday.com/laundry/hlac-offers-laundry-checklist-tool-infection-preventionists>.

11/18, Revised 4/2019, 1/2020

TRANSMISSION BASED PRECAUTIONS

The facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based Precautions shall only be used when the spread of infection cannot be reasonably prevented by less restrictive measures.

Placing a Resident on Transmission-Based Precautions:

1. A physician's order is required to place a resident on transmission-based precautions, please see standing orders.
2. Nurse noting order will notify POA/family member of order.
3. Nurse will notify RN Manager, Infection Preventionist (IP), and Social Services of precaution initiation.
4. Infection Preventionist (IP) will notify the Public Health Department and other necessary government entities necessary for all reportable diseases as well as outbreaks within the facility.
5. Nurse will notify housekeeping and dietary if resident is confined to room or has limited movement outside of their room.
6. Housekeeping will initiate additional disinfection on all high touch surfaces in common areas.
7. Dietary staff will initiate disposable meal service if necessary.
8. Nurse noting order will update the care plan to include specific precautions.

Procedure for Transmission-Based Precautions:

1. Nurse will assign staff to obtain isolation station and place it inside resident's door. Ensure isolation station contains the following:
 - a. Signs specifying precaution type-contact, droplet, modified droplet, airborne, or modified airborne as well as a visitors education sign and pictorial of donning and doffing PPE.
 - b. Surgical Masks or Rebreathers such as N95

- c. Gowns
 - d. Gloves
 - e. Face shields or goggles
 - f. Biohazard red bags to place in appropriate container, one for linens and one for trash (if indicated for regulated waste)
2. Place isolation specific instructions [i.e. contact, (modified) droplet, (modified) airborne] in isolation station. Once you have entered the resident care area, you cannot return to the supply station or med room for forgotten supplies unless you remove PPE, perform hand hygiene, retrieve items and start over with clean PPE. Once a disposable item enters the resident's room and is not used, it must stay in resident's room until used or thrown away. This disposable item cannot go back to general supply as it is now considered contaminated. Items taken into the room must be charged for at that time.
 3. If a non-disposable item is brought into an isolation room it must be disinfected using an EPA registered disinfectant prior to being used on another resident, i.e., oxygen monitor, resident transfer equipment.
 - a. If an item cannot be safely disinfected or if you are unsure, please check with Infection Preventionist prior to using.
 4. Regulated Waste pertinent to this procedure is defined as:
 - a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).
 - b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
 - c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
 5. In the case of Regulated Waste and Contaminated Healthcare Linen:
 - a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.
 6. For residents on precautions dining in their room, refer to: Isolation Meals Procedure.

Removing a Resident from Transmission Based Precautions:

2. Precaution orders must be discontinued to take the resident off isolation, please see standing orders. Notify pertinent parties i.e.: Housekeeping, Infection Preventionist, DNS, Dietary, etc. as appropriate.
3. Assign staff to discard all disposable supplies and wound supplies that are in the resident's room.
4. Wipe down dedicated isolation vital sign equipment box with BP cuff, stethoscope and temperature probe and any other isolation room equipment with an EPA registered disinfecting wipe and return vital sign equipment box with cleaned equipment to the medication room.
5. Housekeeping to be notified to do terminal cleaning of resident's room.

6. Nurse to update resident's care plan.

STANDARD PRECAUTIONS

Purpose:

It is the intent of this facility (with accordance to CDC recommendations) that:

1. All resident blood and body fluids will be considered potentially infectious
2. Standard Precautions are indicated for all residents.

Procedure:

1. Gloves should be worn whenever exposure to the following is planned or anticipated
 - a) Blood/blood products/body fluids with visible blood
 - b) Urine
 - c) Feces
 - d) Saliva
 - e) Mucous membranes
 - f) Wound drainage
 - g) Drainage tubes
 - h) Non-intact skin
 - i) Performing venipuncture or invasive procedures
2. Surgical masks should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids and with resident on droplet precautions who are unable to practice cough etiquette.
3. Rebreather masks such as N95 masks should be worn during procedures that are likely to generate droplets/aerosolized fluids during cares with resident with suspected or diagnosed airborne transmission diseases and with resident on airborne precautions who are unable to practice cough etiquette.
4. Gowns/Aprons should be worn when there is potential for soiling clothing with blood/body fluids and possibly contaminated resident environment as well as with residents on droplet precautions who are unable to practice cough etiquette.
5. Goggles or face shields should be worn during procedures that are likely to generate droplets, sprays or aerosolized contaminants of blood/body fluids and with resident on droplet precautions who are unable to practice cough etiquette.
6. Private Room should be used when possible if not cohort residents with the same pathogens.
7. Hand hygiene refer to procedure on hand hygiene.
8. Trash/Linens will be bagged **prior** to leaving the residents' room, in red biohazard bags alerting about the possible contamination of pathogens.

CONTACT PRECAUTIONS

Purpose:

It is the intent of this facility to use contact precautions to decrease the risk of contract transmission of infectious agents. Extent of precautions will be determined by the Infection Preventionist in consultation with the facility's medical director, using the *CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

Contact Precautions shall be used in addition to Standard Precautions for residents with infections that can be transmitted by either direct resident contact or by contact with items in the resident's environment.

Resident Placement

1. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement, with a private or unshared bathroom.

Personal Protective Equipment (PPE)

1. Hand hygiene should be performed prior to applying PPE.
2. Gown and gloves should be worn when entering the room and while providing care for a resident or residents environment.
3. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
4. Gloves and gown should be removed before leaving the resident's room and hand hygiene should preformed immediately.
5. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items.

Patient Transport

1. Activities of the resident may need to be limited.
2. If the resident leaves the room, precautions should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.

Equipment for resident with infection and/or a contagious disease

1. Dedicated resident-care equipment should be considered for the resident and left in the room for the duration of the precautions.
2. If use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident using EPA approved, pathogen specific, products following the manufacturing instructions before use for another resident.
3. A private toilet or commode will be initiated for residents confirmed or suspected C-diff. Clean equipment used for residents with *Clostridium difficile* (C-diff.) with 1:9 dilution of bleach:water and allow to air dry.

Regulated Waste during Transmission Precautions pertinent to this procedure is defined as:

- a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).

- b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
 - c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
2. In the case of Regulated Waste and Contaminated Healthcare Linen:
 - a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.
3. For residents on precautions dining in their room, disposable meal service should be utilized.

DROPLET PRECAUTIONS

Purpose:

It is the intent of this facility to use droplet precautions to decrease the risk of droplet transmission of infectious agents. Extent of precautions will be determined by the Infection Preventionist in consultation with the facility's medical director, using the *CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

Droplet Precautions shall be used in addition to Standard Precautions for residents with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the residents coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning.

Resident Placement:

1. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement, with a private or unshared bathroom.

Personal Protective Equipment (PPE)

1. Hand hygiene should be performed prior to applying PPE.
2. Gown, gloves and surgical face mask should be worn when entering the room and while providing care for a resident.
3. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
4. Gloves, gown and surgical face mask should be removed before leaving the resident's room and hand hygiene should be performed immediately.

5. After glove removal and hand washing, hands should not touch potentially contaminated environmental surfaces or items.

Transport

Movement and transportation of the resident will be limited. If transport is necessary, contact receiving provider to inform about precautions utilized as well as infecting pathogen. Resident should be provided mask to minimize dispersal of droplets.

Equipment for resident with infection and/or a contagious disease

1. Dedicated resident-care equipment should be considered for the resident and left in the room for the duration of the precautions.
2. Resident paper service meals provided in resident room for the duration of the precautions.
3. If use of common equipment or items is unavoidable, the items should be adequately cleaned and disinfected using EPA approved, pathogen specific, products following the manufacturing instructions before use for another resident.

Regulated Waste during Transmission Precautions pertinent to this procedure is defined as:

- a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).
- b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
- c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
4. In the case of Regulated Waste and Contaminated Healthcare Linen:
 - a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.
5. For residents on precautions dining in their room, disposable meal service should be utilized.

AIRBORNE PRECAUTIONS

6. Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended within aerosolized respirable particles are in the air.
 - a. Residents will be in a single room if possible, if not possible residents may cohort with resident infected with the same pathogen.
 - b. Order will be written for Airborne Isolation precautions.
 - i. Door to resident room to remain closed, air scrubber if available will be in place and operating at all times.

- ii. Posting to outside of the door specifying Airborne Isolation Precautions (see attached) and the donning/doffing personal protective equipment (PPE) procedural visual aid should be placed near the PPE (see attached).
- iii. Paper tray service and isolation dedicated vital assessment equipment will be used.
- iv. PPE includes face shields, N95 (or CDC accepted rebreather), gown and gloves.
- v. Hand hygiene performed prior to donning and after doffing PPE and proper donning and doffing followed to minimize contamination.
- vi. PPE will be monitored regularly, should we experience a shortage of PPE the CDC recommendations will be followed for conventional capacity, conserving capacity and crisis capacity.
- c. PPE procedure for staff assisting resident must include:
 - i. Perform hand hygiene
 - ii. Apply gown
 - iii. Apply N-95 rebreather pinching the adjustable nose clip for a tight fit
 - iv. Perform User Seal Checks. *to avoid self-inoculation hand hygiene and donning/doffing gloves must be used for this procedure. *
 - 1. Positive Pressure seal check:
 - a. don clean non-sterile gloves
 - b. apply rebreather
 - c. exhale gently while blocking the paths for air to exit
 - d. During a successful check the facepiece is slightly pressurized before increased pressure causes outward leakage.
 - 2. Negative pressure user seal check.
 - a. With clean non-sterile gloves still in place
 - b. Inhale sharply while blocking the paths for air to enter the facepiece.
 - c. During a successful check the facepiece will either collapse slightly or pull tight to face under the negative pressure.
 - d. Doff gloves and perform hand hygiene.
 - v. Apply eye protection
 - vi. Apply clean non-sterile gloves
- d. Prior to leaving patient area:
 - i. Remove gloves
 - ii. Remove gown
 - iii. Remove eye protection
 - iv. Remove N-95 rebreather
 - v. Perform hand hygiene

Transport

Movement and transportation of the resident will be limited. If transport is necessary, contact receiving provider to inform about precautions utilized as well as infecting

pathogen. Resident should be provided mask to minimize dispersal of droplets, aerosolized particles.

Regulated Waste during Transmission Precautions pertinent to this procedure is defined as:

- a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).
 - b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
 - c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
7. In the case of Regulated Waste and Contaminated Healthcare Linen:
- a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.
8. For residents on precautions dining in their room, disposable meal service should be utilized.

DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS ("ISOLATION")

1. Transmission-Based Precautions remain in effect for limited periods of time (i.e. while the risk of transmission of the infectious agent persists or for the duration of the illness).
2. Strategies for determining to discontinue precautions-will be determined by the Infection Preventionist in consultation with the facility's medical director, using the *CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.
 - a. Consider the known pattern of persistence and shedding of infectious agents associated with natural history of the infectious process and its treatment.
 - b. Utilize culture or antigen-detection test to document eradication of the pathogen.
 - c. Symptoms of disease is resolved.
 - d. Adhere to State laws and regulations.
3. Precaution orders must be discontinued to take the resident off isolation, please see standing orders. Notify pertinent parties i.e.: Housekeeping, Infection Preventionist, DNS, Dietary, etc. as appropriate.
4. Assign staff to discard all disposable supplies and wound supplies that are in the resident's room.
5. Disinfect dedicated isolation vital sign equipment box with BP cuff, stethoscope and temperature probe and any other isolation room equipment with an EPA registered disinfectant and return vital sign equipment box with cleaned equipment to the medication room.
6. Housekeeping to be notified to do terminal cleaning of resident's room.
7. Nurse to update resident's care plan.

11/18, Revised 5/2019, 4/20

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(e) and F583 – Right to Personal Privacy 583.10 (h)(1).
- b. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- c. Pineles L, Et Al. *Infection Control Hospital Epidemiol.* 2019; *doi10.1017/ice20.19.117*
<https://www.healio.com/infectious-disease/nosocomial-infections/news/online/%7B555ee2ef-dec6-431e-80c2-d7cc986646eb%7D/nursing-home-infection-control-should-target-environments-outside-resident-rooms>
- d. Centers for Disease Control and Prevention, *Prevent the Spread of C. diff.* (Reviewed November 4, 2019) https://www.cdc.gov/cdiff/prevent.html#anchor_1540398538.
- e. Southeastern Idaho Public Health, *Epidemiology & Communicable Disease*.
https://www.siphidaho.org/comhealth/epi_comm.php.
- f. Southeastern Idaho Public Health, *Idaho Reportable Disease List*. (Updated 1/2013)
https://www.siphidaho.org/comhealth/pdf/Reportable_Disease_List_rev2014.pdf.

Centers for Disease Control and Prevention. *Standard Precautions for all Patient Care* (Reviewed January 26, 2016). <https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>

RESPIRATORY INFECTION CARE PROCEDURE

Purpose:

Respiratory infection procedure is created to establish procedures for controlling exposure to respiratory infections of unknown pathogen to limit outbreaks in the Home.

1. Place all residents with respiratory symptoms in a private room with a private bathroom or bedside commode if possible, if no private room is available cohort resident with a resident with like symptoms.
2. Enter an order for droplet precautions, unless specified pathogen indicates otherwise, follow transmission precaution procedure for appropriate precaution.

Droplet Precautions shall be used in addition to Standard Precautions for residents with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the residents coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning.

Resident Placement:

2. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement, with a private or unshared bathroom.

Personal Protective Equipment (PPE)

6. Hand hygiene should be performed prior to applying PPE.
7. Gown, gloves and surgical face mask should be worn when entering the room and while providing care for a resident.
8. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
9. Gloves, gown and surgical face mask should be removed before leaving the resident's room and hand hygiene should be performed immediately.
10. After glove removal and hand washing, hands should not touch potentially contaminated environmental surfaces or items.

Transport

Movement and transportation of the resident will be limited. If transport is necessary, contact receiving provider to inform about precautions utilized as well as infecting pathogen. Resident should be provided mask to minimize dispersal of droplets.

Equipment for resident with infection and/or a contagious disease

4. Dedicated resident-care equipment should be considered for the resident and left in the room for the duration of the precautions.
5. Resident paper service meals provided in resident room for the duration of the precautions.
6. If use of common equipment or items is unavoidable, the items should be adequately cleaned and disinfected using EPA approved, pathogen specific, products following the manufacturing instructions before use for another resident.

Regulated Waste during Transmission Precautions pertinent to this procedure is defined as:

- a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).
 - b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
 - c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
9. In the case of Regulated Waste and Contaminated Healthcare Linen:
 - a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.

10. For residents on precautions dining in their room, disposable meal service should be utilized.
3. Notify Provider, Administrator, DNS, Infection Prevention Nurse and family.
4. When at least 3 patients are ill within 72 hours of each other Infection Prevention Nurse will notify Southeaster Health Department.
5. Housekeeping to increase cleaning and disinfection of all high touch surfaces.
6. Transport aide to clean/disinfect transport vehicle between each transport.

Revised 01/15, Revised 04/19, 4/20

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- b. CDC, *Information for Health Professionals (Influenza)*. (Reviewed January 2, 2020). <https://www.cdc.gov/flu/professionals/index.htm>.
- c. CDC, *Interim Guidance for Influenza Outbreak and Management in Long Term Care and Post-Acute Care Facilities*. (Reviewed November 1, 2019). <https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>.
- d. CDC, *Influenza Antiviral Medications: A Summary for Clinicians*. (Reviewed January 15, 2020). <https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>.

United States Environmental Protection Agency, *Selected EPA-Registered Disinfectants*. (Updated April 16, 2020). <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>

MRSA/VRE ADMISSION GUIDELINES

The following are admission guidelines for residents diagnosed with MRSA/VRE:

1. Prior to admission, determine if the resident has infection or colonization of MRSA/VRE.
Note: If the resident has an infection with MRSA/VRE, admission may be delayed until there is evidence that colonization has occurred or the infection has been eradicated.
 - a. Colonization is determined by the absence of clinical signs and symptoms of infection 48 hours after the completion of antibiotic, but with a positive culture for MRSA/VRE.
 - b. If colonization has occurred, the admission committee will review the information to determine the facility's ability to accommodate the resident. This may be determined by meeting the criteria below for a resident colonized with MRSA/VRE.
 - c. Eradication of MRSA/VRE is determined by two consecutive negative cultures obtained 24 hours apart. Cultures are to be obtained from the nares, inguinal areas, sputum and urine. (Eradication of MRSA/VRE is not routinely attempted in the long term health care setting due to its marginal success rate and prevalence for the recurrence of MRSA/VRE in the absence of ongoing surveillance.)
2. The following are general guidelines for residents with colonized MRSA:
 - a. The ideal room placement is a private room or a room with other colonized residents.
 - b. The MRSA colonized resident can share a room with a non-MRSA colonized resident who has no invasive sites (i.e. Foley catheter, wound(s), NG tube, etc.). Do not place a colonized resident with other residents who are severely immunocompromised or severely debilitated.
 - c. Gloves are to be worn when providing resident care.
 - d. Gowns are to be worn only if soiling with drainage or secretions is likely.
 - e. Masks are to be worn when in close contact with residents who have respiratory infections.
 - f. Face shield/goggles are to be worn when emptying urinary catheter bags.

Revised 01/15, 11/18

GUIDELINES FOR RESIDENTS WITH MRSA/VRE INFECTION

1. Following documented lab findings of MRSA/VRE:
 - a. Notify the attending physician immediately and obtain orders for treatment and for contact precautions.
 - b. Update the resident care plan and CNA flow sheets with contact precaution guidelines. Place sign on door of residents room to notify staff/visitors of the precautions needed before entering the room.
 - c. When possible and/or appropriate, place the resident in a private room or with another resident who has colonized MRSA or one who has no invasive sites or wounds.
 - d. Follow instructions in disease specific isolation precautions for multi-drug resistant organisms or place on contact isolation.
 - e. Orders for antibiotics in accordance with sensitivity will be requests. These may include the use of Bactroban or similar antibiotic ointment to the nares at the discretion of the physician and should be continued until the second negative cultures is obtained.
 - a) Note that renal function, marrow tolerance, and age must be taken into consideration if using Vancomycin.
 - b) *If indwelling catheter is present, change the catheter two days after antibiotic therapy is started. It should be changed again two days after the antibiotic therapy is discontinued.

Maintain contact isolation until:

1. Forty-eight hours after a course of antibiotic treatment and signs and symptoms have ceased.
2. Two negative cultures have been obtained at least 24 hours apart; and
3. Infection Preventionist has reviewed and approved discontinuing the isolation or contact precautions.

Discontinuation of Contact Precautions.

- A patient with MRSA/VRE may be taken off Contact Precautions after two sets of cultures taken 24 hours apart are found to be negative. These cultures should be taken from each previously infected or colonized site and from the anterior nares. These cultures should be taken at least 48 hours after all antibiotics have been discontinued.
- If results of culture indicate colonized MRSA, then follow steps for management of colonized residents.
- Decolonization or Eradication regimens are not sufficiently effective to warrant routine use. Therefore, most healthcare facilities have limited the use of decolonization to MRSA outbreaks, or other high prevalence situations, especially those affecting special care units. (Management of MDRO in HealthCare Settings, 2006).

REPORTING EMPLOYEE INFECTIONS

Purpose:

To promote an environment to support employees, allowing for time off, and controlling the spread of communicable diseases and to insure identification and follow-up of infections among employees.

Procedure:

1. Any employee having an active infection should not report to work.
2. Employees/contractors are responsible for contacting the Charge Nurse or Infection Preventionist to report an infectious illness.
3. The Infection Preventionist is responsible for completing and maintaining the employee infection record whenever an infection is reported.
4. The Infection Preventionist will follow the facility's policy on work restrictions for communicable diseases with guidance from CDC *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* (Updated July 2019).
5. The Infection Preventionist nurse will consult with the Public Health Department as needed to determine current standards of practice with communicable diseases.
6. Each reported infection will be assessed and managed on a case by case basis. A physician exam/treatment may be required as appropriate.

Revised 05/09, 11/18, 4/2020

References:

- f. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- g. CDC, *Nursing Homes and Assisted Living (long-term Care Facilities) Prevention Tools*. (Updated July 10, 2019). <https://www.cdc.gov/longtermcare/prevention/index.html>.
- h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* (Updated July 2019). <http://www.cdc.gov/infectioncontrol/guidelines/isolation>

SUMMARY OF IMPORTANT RECOMMENDATIONS AND WORK RESTRICTIONS FOR PERSONNEL WITH INFECTIOUS DISEASES

DISEASE/PROBLEM	WORK RESTRICTIONS	DURATION
Conjunctivitis	Restrict from resident contact and contact with the resident's environment.	Until discharge ceases.
Cytomegalovirus (CMV) infection	No restrictions.	
<p align="center">Diarrheal diseases</p> <p>Acute stage (diarrhea with other symptoms)</p> <p>Convalescent stage, Salmonella spp.</p>	<p>Restrict from resident contact, contact with the resident's environment, or food handling.</p> <p>Restrict from care of high-risk residents.</p>	<p>Until symptoms resolve.</p> <p>Until symptoms resolve; consult with local and state health authorities regarding need for negative stool cultures.</p>
Diphtheria	Exclude from duty.	Until antimicrobial therapy completed and 2 cultures obtained >24 hours apart are negative.
Enteroviral infections	Restrict from immune-compromised residents and their environments.	Until symptoms resolve.
H1 N1	Exclude from duty.	For 7 days or until symptoms have resolved, whichever is longer.
Hepatitis A	Restrict from resident contact, contact with the resident's environment, or food handling.	Until 7 days after onset of jaundice.

<p align="center">Hepatitis B</p> <p>Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures</p> <p>Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures</p>	<p>No restrictions unless epidemiologically linked to transmission of infection; refer to state regulations; standard precautions should always be observed.</p> <p>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations.</p>	<p>Until hepatitis B e antigen is negative.</p>
<p align="center">Hepatitis C</p>	<p>No recommendation.</p>	
<p align="center">Herpes simplex</p> <p>Genital</p> <p>Hands (herpetic whitlow)</p> <p>Orofacial</p>	<p>No restrictions.</p> <p>Restrict from resident contact and contact with the resident's environment.</p> <p>Evaluate for need to restrict from care of high-risk residents.</p>	<p>Until lesions heal.</p>
<p align="center">Human Immunodeficiency Virus</p>	<p>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations.</p>	
<p align="center">Measles</p> <p>Active</p> <p>Post exposure (susceptible personnel)</p>	<p>Exclude from duty.</p> <p>Exclude from duty.</p>	<p>Until 7 days after the rash appears.</p> <p>For the 5th day after 1st exposure through 21st day after last exposure and/or 4 days after rash appears.</p>

Meningococcal infections	Exclude from duty.	Until 24 hours after start of effective therapy.
Mumps		
Active	Exclude from duty.	Until 9 days after onset of parotitis.
Post exposure (susceptible personnel)	Exclude from duty.	For the 12 th day after 1 st exposure through 26 th day after last exposure or until 9 days after onset of parotitis.
Pediculosis	Restrict from patient contact.	Until treated and observed to be free of adult and immature lice.
Pertussis		
Active	Exclude from duty.	From beginning of catarrhal stage through 3 rd week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy.
Post exposure (asymptomatic personnel)	No restrictions, prophylaxis recommended.	
Post exposure (symptomatic personnel)	Exclude from duty.	Until 5 days after start of effective antimicrobial therapy.
Rubella		
Active	Exclude from duty.	Until 5 days after rash appears.
Post exposure (susceptible personnel)	Exclude from duty.	From 7 th day after 1 st exposure through 21 st day after last exposure.
Scabies	Restrict from patient contact.	Until treated.
Staphylococcus aureus infection		
Active, draining skin lesions	Restrict from contact with patients and patient's environment or food handling.	Until lesions have resolved.
Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism	

Streptococcal infection, group A	Restrict from resident care, contact with resident's environment, or food handling.	Until 24 hours after adequate treatment started.
Tuberculosis		
Active disease	Exclude from duty.	Until proven noninfectious.
PPD converter	No restriction.	
Varicella		
Active	Exclude from duty.	Until all lesions dry and crust.
Post exposure (susceptible personnel)	Exclude from duty.	From 10 th day after 1 st exposure through 21 st day (28 th day if VZIG given) after last exposure
Viral respiratory infections, acute febrile	Exclude from duty.	Until acute symptoms resolve and no fever for 24 hours.
Zoster		
Localized, in healthy person	Cover lesions; restrict from care of high-risk patients (those susceptible to varicella and who are at increased risk of complications of varicella, such as neonates and immunocompromised persons of any age).	Until all lesions dry and crust.
Generalized or localized in immunosuppressed person	Restrict from patient contact.	Until all lesions dry and crust.
Post exposure (susceptible personnel)	Restrict from patient contact.	From 8 th day after 1 st exposure through 21 st day (28 th day if VZIG given) after last exposure, or, if varicella occurs, until all lesions dry and crust .

ANTIBIOTIC STEWARDSHIP PROGRAM

Purpose:

The Antibiotic Stewardship Program is part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.

Policy Explanation and Compliance Guidelines:

28. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility.
 - a. Infection Preventionist – coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff.
 - b. Director of Nursing – serves as back up coordinator for antibiotic stewardship activities, provides support and oversight, and ensures adequate resources for carrying out the program.
 - c. Administrator – provides adequate resources for carrying out the program and ensures review of antibiotic use and resistance data at QAPI meetings.
29. The Medical Director, Consultant Pharmacist, and Attending Physicians support the program via active participation in developing, promoting, and implementing a facility-wide system for monitoring the use of antibiotics.
 - a. Medical Director – serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members.
 - b. Consultant Pharmacist – reviews antibiotics prescribed to residents during their medication regimen review and serves as resource for questions related to antibiotics.
 - c. Attending Physicians – prescribe appropriate antibiotics in accordance with standards of practice and facility protocols.
30. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program.
31. The program includes antibiotic use protocols and a system to monitor antibiotic use.
 - a. Antibiotic use protocols:
 - i. Laboratory testing shall be in accordance with current standards of practice.
 - ii. The facility uses the (CDC’s NHSN Surveillance Definitions) to define infections.
 - iii. The Loeb Minimum Criteria are used to determine whether or not to treat an infection with antibiotics.
 - iv. All prescriptions for antibiotics shall specify the dose, duration, and indication for use.
 - b. Monitoring antibiotic use:
 - i. All antibiotic orders shall be reviewed for appropriateness.
 - ii. Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy).
32. Education regarding antibiotic stewardship shall be provided at least annually to facility staff.
33. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to:
 - a. Action plans and/or work plans associated with the program.
 - b. Assessment forms.
 - c. Antibiotic use protocols/algorithms.
 - d. Data collection forms for antibiotic use, process, and outcome measures.
 - e. Quarterly reports.

34. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's QAPI meetings.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F881 – Antibiotic Stewardship Program. 42 C. F. R. 483.80 (a)(3).
- b. CDC, *The Core Elements of Antibiotic Stewardship for Nursing Homes*. (February 28, 2017 Reviewed). <https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html>
- c. JSTOR, SHEA The Society for Healthcare Epidemiology of America, *Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGreer Criteria*. (October 2012). <https://www.jstor.org/stable/pdf/10.1086/667743.pdf?refreqid=excelsior%3A77a1a349b25e55ff6ec07118af60a1ac>
- d. Infection Control Hospital Epidemiology, *Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term-Care Facilities: Results of Consensus Conference*. (February 2001). <https://www.ncbi.nlm.nih.gov/pubmed/11232875/>

11/18, 01/19, Revised 05/19, Revised 1/2020

EQUIPMENT/SUPPLIES CLEANING/DISPOSAL SCHEDULE

All personal resident equipment will be clearly dated and marked with the resident's name. Staff will gather the appropriate disinfectant equipment, perform hand hygiene, don PPE based on the suspected pathogen and minimally standard precautions. After cleaning/disinfection staff will properly remove and dispose PPE then preform hand hygiene.

1. To maintain a closed drainage system, Foley catheters and bags will only be changed if leakage or blockage occurs or 48 hours after antibiotic therapy for a UTI has been completed.
2. Denture cups will be discarded and re-issued monthly.
3. Nebulizer machine, tubing and attachments will be changed as ordered. Nebulizer tubing & attachments will be soaked and rinsed with water, then set out on a paper towel to dry Q NOC.
4. Oxygen tubing will be changed and dated monthly, 48 hours after antibiotic therapy for a respiratory infection and PRN as needed if it touches possibly contaminated surfaces such as but not limited to: floors, linens, ect.
5. In room suction machines will utilize disposable canisters and discarded in a biohazard container when full. Tubing/suction catheter will be changed after each use if used PRN. If ongoing use for an individual resident is required tubing/suction catheter change will be marked, dated and changed daily.

6. Tube feeding pole and pump will be wiped down weekly (NOC shift) and PRN when visibly soiled.
7. Tube feeding syringe will be changed daily.
8. Urinals will be discarded and replaced weekly.
9. Urine/stool specimen hats shall be marked with the residents name and will be discarded following individual use.
10. Water Pitchers will be changed daily.
11. Portable Suction Machine (Crash Cart) will be cleaned weekly, following the manufacturer's recommendations for cleaning.
12. Bladder Scanner will be cleaned weekly and after each use, following the manufacturer's recommendations for cleaning.
13. Individual glucometers are cleaned/disinfected weekly and PRN when soiled.
14. Shared equipment such as but not limited to: vital carts, sara stands, shower chairs, ect, will be disinfected between each use with disinfectant wipes unless specified otherwise by the manufacturer's recommendations for cleaning.
15. During outbreak housekeeping will increase cleaning and disinfection of high touch surfaces.
16. Transport aide will clean/disinfect high touch surfaces between transports.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii) Standard and transmission-based precautions to be followed to prevent spread of infections.
- b. Centers for Disease Control and Prevention, (Coronavirus Disease 2019) *Cleaning and Disinfecting Your Facility*. (Reviewed April 14, 2020). <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>
- c. United States Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*. (Updated April 16,2020). <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>
- d. United States Environmental Protection Agency, *Selected EPA-Registered Disinfectants*. (Updated April 16,2020). <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>

Revised 02/15, 11/18, 2/19, 4/20

CLIA-WAIVED FACILITY LAB TESTS

1. CLIA-Waived lab tests are those tests that are conducted in the facility by a licensed nurse e.g. finger-stick blood glucose, urinstrips, stool and/or emesis guaiac.
2. Lab tests performed in the facility can be the result of a physician's order or physician's standing order.
3. The results of any lab tests performed in the facility (including negative tests(s)) shall be documented/scanned into PCC and communicated to the resident's primary/ordering physician.

11/18

ISOLATION MEALS

1. Nursing staff will inform the Dietary department of residents in isolation who will require tray delivery.
2. Meals will be plated on disposable dishes / utensils, delivered by covered service carts and served on covered dishes.
3. Meals will be delivered to residents promptly. Staff will sanitize their hands prior to and after delivering the resident's meal.
4. Resident's food will be uncovered when presented by staff delivering their meals. All items on the meal tray (i.e. lids, cups, glasses, coverings) will remain in the resident's room until they can be discarded.
5. Nursing staff will remove any gross contamination, bag the dishes in a red biohazard disposable garbage sack.
6. The nursing staff will inform the Dietary department when a resident is no longer in isolation and regular meal service will resume.

11/18

TERMINAL CLEANING OF RESIDENT ROOM

The purpose of this cleaning and disinfection process is to remove bacterial contamination from environmental surfaces and equipment surfaces where residents receive care in order to prevent

the transmission of the microorganism from resident to resident, from residents to healthcare workers, and from residents to visitors. Thorough environmental cleaning and disinfection of rooms where residents with multidrug-resistant organisms (MDROs) have resided is essential to controlling the spread of infection.

Procedure:

1. Environmental services (ES) personnel must use all barrier precautions (such as masks, gloves and gowns) when cleaning in rooms or units where surfaces may be contaminated with infectious microorganisms.
2. ES personnel should use Environmental Protection Agency (EPA)-approved, hospital-grade cleaning and disinfectant products to clean the following items:
 - a. Bed:
 - i. Top, front and sides of the bed's headboard and foot board.
 - ii. Bedframe top side and underside.
 - iii. Side rails-all surfaces of every side rail.
 - b. Mattress – all surfaces of mattress top, bottom, sides.
 - c. Nurse-call device and cord.
 - d. All high-touch areas in the room including tabletops, bedside tabletop and inner drawer, phone and cradle, armchairs, door and cabinet handles, light switches, closet handles, TV remote control, etc.
 - e. Resident bathroom: start with the highest surface and clean the toilet last; clean the sink and counter area, including sink fixtures, and if there is a shower, the support bars and shower fixtures and surfaces.
 - f. All other horizontal or other surfaces in the room that may have become contaminated.
3. Privacy curtains should be removed and placed in a plastic bag in the room.
4. Cleaning of window curtains, ceiling or walls is not necessary unless visibly soiled.
5. Following the terminal cleaning of a resident room, gloves should be removed so as to avoid touching the outside of the gloves.
6. Perform hand hygiene prior to donning a new set of gloves

11/18

RESIDENTS WITH PROVEN OR SUSPECTED LATEX ALLERGY

Purpose:

To avoid exposing a latex sensitive resident to contaminated items that may cause a reaction such as skin irritation or life-threatening anaphylactic shock.

Procedure:

1. If the history and any tests are suggestive of latex allergy then the following steps shall be taken:
 - a. All latex containing equipment should be removed from the room and the room cleaned after its removal.
 - b. Replace necessary equipment with latex-free alternatives e.g. gloves, adhesive tape etc. (reference list below)
 - c. Staff should wash their hands thoroughly upon entering room or touching the resident.
 - d. A Latex Allergy sign should be placed above the resident's bed.
 - e. If the resident needs radiological, wound or other clinic visits, please inform the relevant staff regarding the sensitivity.
2. The following products may be sources of latex:
 - a. Gloves
 - b. BP cuffs
 - c. Bandages
 - d. Rubber bands
 - e. IV equipment
 - f. Pulse Oximeter
 - g. Urinary catheters
 - h. IV injection parts in IV fluid bags
 - i. Anti-embolism stockings
 - j. Adhesive tape
 - k. Hot water bottles
 - l. Tourniquets
 - m. Rubber bungs on drug vials-remove before use, do not inject or aspirate through them.
3. The following is a list of latex-free equipment:
 - a. Adhesive dressings: Vecafix, Tegaderm, Mepore
 - b. Urinary Catheters: Used silicone based
 - c. Monitoring equipment: ECG electrodes-Conmed, Cleartracce
 - d. Goves: Vinyl and Nitrile gloves
 - e. Our syringes are lates-free
 - f. IV equipment: Baxter IV fluids-do not use injection bung (may contain latex)
 - g. Wrap residents finger with tegaderm before placing pulse oximeter.

Influenza Vaccination

Purpose:

To provide residents with the opportunity to be protected against the Influenza Virus in accordance with state and federal guidelines and with interventions that are consistent with current professional standards of practice.

To minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents and staff members **annual** immunization against influenza.

"Medical Contraindication" is a condition or risk that precludes the administration of a treatment or intervention because of the substantial probability to harm to the individual may occur.

Policy Explanation and Compliance Guidelines:

1. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine.
2. Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulation in the facility's geographic area.
3. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved "standing orders".
4. Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's **current** vaccine information statement relative to the influenza vaccination.
5. Vaccine Information Statements (VIS) will, as appropriate, be supplemented with visual presentation or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of the influenza vaccine.
6. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record.
7. Residents and staff members retain the right to refuse influenza immunization.
8. An entry will be made in the resident's chart reflecting the site and date vaccination was given and the resident's tolerance for it. The resident's medical record will include documentation that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of immunization, and the resident received or did not receive the immunization due to medical contraindication or refusal.
9. In case of lack of availability of the influenza vaccine, or other issue with the availability leading to an inability to implement the influenza vaccine program, the facility will demonstrate:
 - a. The vaccine has been ordered and the facility received either the vaccine or a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available.
 - b. Plans are developed on how and when the vaccines are to be administered.

- c. Residents have been screened to determine how many and which residents are eligible and wish to receive the vaccine; and
- d. Education regarding immunizations has been implemented.

ANNUAL FLU VACCINATION CRITERIA

1. A physician order is on file stating the residents may receive the flu vaccine.
2. The resident is afebrile.
3. The resident is not currently taking antibiotics. If the resident is currently taking an antibiotic, the physician is to be consulted prior to administration of this vaccine.
4. The resident has no known allergies to eggs. Consult with the Physician if an allergy is identified.
5. Following administration of the flu vaccine, the resident will be placed on alert charting for approximately 72 hours. During this time, the nurse will inspect the vaccination site and obtain the resident's temperature daily to ensure that an adverse reaction has not occurred.

Seasonal Influenza Symptoms:

1. Temperature equal to or greater than 99.0 degrees
2. Dry Hacking Cough
3. Muscular aches & pains
4. Chills
5. Tiredness (malaise)
6. Runny nose
7. Sneezing
8. Nasal stuffiness
9. Headache
10. Sore Throat
11. Chest Discomfort (congestion)
12. Loss of appetite
13. Dizziness and/or nausea, vomiting. Diarrhea is common.

INFLUENZA OUTBREAK GUIDELINES

Purpose:

Influenza outbreak guidelines are created to establish procedures for prevention of and controlling exposure to influenza and reduce the risks and possible complications from influenza infection.

7. Offer/administer influenza antiviral treatment/chemoprophylaxis to residents annually and during outbreak.
8. Once an outbreak has been established, all residents who have confirmed or suspected influenza should receive antiviral treatment immediately.
9. Treatment should not wait for laboratory confirmation of influenza.
10. Antiviral treatment works best when started within the first 2 days of symptoms. However, these medications can still help when given after 48 hours to those that are very sick, such as those who are hospitalized, or those who have progressive illness.
11. Two influenza antiviral drugs are currently recommended for use against circulating influenza viruses. These are oseltamivir, available as a pill or suspension, zanamivir, available as an inhaled powder using a disk inhaler device and xofluzza a one time dose pill form.
12. Amantadine and rimantadine are **NOT** recommended for use because of high levels of antiviral resistance among circulating influenza A viruses.
13. The recommended dosing and duration of antiviral treatment is twice daily for 5 days. Longer treatment courses for patients who remain severely ill after 5 days of treatment can be considered. Dosage adjustment may be required for children and persons with certain underlying conditions. Clinicians should consult the manufacturers' package insert for recommended drug dosing adjustments and contraindications.
14. Having preapproved orders from physicians or plans to obtain orders for antiviral medication on short notice can substantially expedite administration of antiviral medications.
15. Unless contraindicated, all eligible consenting residents should receive antiviral chemoprophylaxis as soon as an influenza outbreak is determined.
16. When at least 2 patients are ill within 72 hours of each other and at least one resident has laboratory-confirmed influenza, the facility should promptly initiate antiviral chemoprophylaxis to all non-ill residents, who occupy the same hallway and dining room table, regardless of whether they received influenza vaccination during the previous fall. However, since staff and residents may spread influenza to residents on other halls, close monitoring of all residents will be ongoing if residents in other hallways are observed and influenza symptoms antiviral chemoprophylaxis will be expanded to include remaining hallways as needed.
17. During an influenza outbreak staff who have received the influenza vaccination will be given priority assignment to the infectious hallways(s).
18. Antiviral chemoprophylaxis is recommended for all non-ill residents living on the same hallway, regardless of their influenza vaccination status, in long-term facilities that are experiencing outbreaks.
19. Antiviral Chemoprophylaxis is meant for residents who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza, to prevent transmission.

20. Use of antiviral drugs for chemoprophylaxis of influenza is a key component of influenza outbreak control in institutions that house residents a higher risk of influenza complications. While highly effective, *antiviral chemoprophylaxis is not 100% effective in preventing influenza illness.*
21. CDC recommends antiviral chemoprophylaxis for a minimum of 2 weeks, and continuing for at least 7 days after the last known case was identified.
22. Nursing staff to review risks vs. benefits with resident and family (DPOA).
 - a. Risks include but are not limited to:
 - i. Nausea
 - ii. Vomiting
 - iii. Dizziness
 - iv. Headaches
 - v. Nose bleeds
 - vi. Red eyes
 - vii. Insomnia
 - viii. Cough
 - ix. Mental / mood changes
 - b. Benefits include:
 - i. Reduction in durations and severity of flu symptoms
 - ii. Reduction in risk of spreading illness
 - iii. Reduction in risk of contracting the flu
 - iv. Reduction in risk of developing complications of the flu including but not limited to: bronchitis, pneumonia, hypoxia and SIRs/Sepsis

11/18, revised 4/2019

PNEUMOCOCCAL VACCINATIONS

Purpose:

To provide the residents of ISVH-P with the opportunity to receive the Pneumococcal Vaccine in accordance with state and federal guidelines and in accordance with current professional standards of practice.

Policy:

It is our policy to offer our residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.

Policy explanation and Compliance Guidelines:

1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Should the resident's medical history show that the resident has received both of the two vaccinations needed to fulfill the lifetime requirement it shall be documented and no further pneumococcal vaccines will be necessary.
2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved "standing orders".
3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization.
 - a. The individual receiving the immunization, or the resident representative will be provided with a copy of CDC's current vaccine information statement relative to that vaccine.
 - b. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding.
4. The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record.
5. The type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with the current CDC guidelines and recommendations.
6. Usually only one (1) pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime. However, based on an assessment and practitioner recommendation, additional vaccines may be provided.
7. A series of vaccinations will be offered to immunocompetent* adults ≥ 65 , depending on current vaccination status and practitioner recommendation:
 - a. **No Previous vaccination (or vaccination status is unknown):** PCV 13 first, then PPSV23 one year later.
 - b. **Previously received PPSV23 before at age ≥ 65 :** PCV 13 at least 1 year after receipt of PPSV23.
 - c. **Previously received PPSV23 before age 65 years who are now aged ≥ 65 :** PCV13 at least 1 year after receipt of PPSV23, then PPSV23 after 5 years of previous vaccination (no earlier than one year of PCV13)
(*Residents who are immunocompromised may receive the series of vaccinations within a shortened interval in accordance with current CDC guidelines and practitioner recommendation, but no sooner than 8 weeks. These residents may receive up to 3 doses of PPSV23.)
8. The resident's medical record shall include documentation that indicates at a minimum, the following:
 - a. The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization.

- b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal.
9. For employees, documentation related to pneumococcal immunization will be maintained in the employee file.

Protocol:

- ISVH-P subscribes to providing the highest quality of care to all of its residents.
- ISVH-P will adhere to the following Pneumococcal Vaccinations Protocol unless directed otherwise by the resident's primary physician.

Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received.

1. Should the resident's medical history show that the resident has received both of the two vaccinations needed to fulfill the lifetime requirement it shall be documented and no further pneumococcal vaccines will be necessary.
2. Should the resident's medical history indicate that the resident has either not received the pneumococcal vaccine, or has not received the second injection needed to complete the lifetime requirement of the following criteria will be followed:
 - a. An order will be obtained for the vaccine and transcribed into the resident's MAR.
 - b. The resident's temperature will be taken prior to administering the vaccine. Vaccination will be delayed for those residents with a fever 100 F or above or the presence of an active upper respiratory infection (URI)
 - c. If a resident declines the pneumococcal vaccine, he or she will be educated to the risks and benefits of receiving the vaccine and document in the resident's chart.
 - d. The vaccine is administered intramuscularly into the deltoid muscle.
 - e. The resident will be monitored for any initial adverse reactions to the vaccine. For the next 72 hours following vaccination; nursing will continue to assess and record any adverse reactions such as low grade fever, malaise, and soreness at the injection site and treat these symptoms as appropriate.
 - f. A nursing entry will be made in the nursing progress notes identifying the date, time and site of injection. The vaccine will be recorded on the Vaccination Record .

XI PHYSICAL / CHEMICAL RESTRAINTS

CHEMICAL RESTRAINTS – USE OF PSYCHOTROPIC MEDICATIONS

Purpose:

Our residents have the right to be free from any chemical restraint imposed for purposes of discipline or convenience and should only be used to treat the resident's medical symptoms. Because of this, the use of psychotropic medications will only be ordered/administered using the following procedure.

Procedure:

1. Prior to obtaining an order for the addition or increase in a psychotropic medication the nurse, along with the resident's physician, must:
 - a) Assess whether the resident's behavioral symptom(s) is in need of some other form of intervention than the use of an antipsychotic medication.
 - b) Assess whether the resident's behavioral symptom(s) is in need of an antipsychotic medication.
 - c) Determine whether the behavioral symptom(s) is transitory or permanent.
 - d) Attempt to determine the cause of the behavior.
 - e) Rule out environmental causes such as excessive heat, noise, overcrowding.
 - f) Rule out medical causes such as pain, constipation, fever, infection.
2. The results of the above shall be documented in the resident's medical chart, by the licensed nurse and physician.
3. Prior to the administration of a new antipsychotic medication and/or prior to the administration of an increase in the dose of a psychotic medication the licensed nurse must:
 - a) Notify the resident and/or responsible party to discuss/explain the potential negative outcomes of chemical restraint use and obtain consent for use.
 - b) Notify Social Services.
 - c) Notify the RN Manager or DNS (if not originally involved in the decision).
 - d) Implement a care plan.
 - e) Implement monitoring tool for observation of potential side effects of medication(s) (on E-MAR).
4. Prior to the use of a PRN psychotropic medication, the licensed staff must first utilize other care planned alternative interventions to alleviate the resident's behavior and document the behavior, the results of the intervention(s) and the outcome of the intervention(s) in the behavior monitoring sheet/nurses notes.
5. Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated.

6. Antipsychotic medications should not be used if one or more of the following is/are the ONLY indication:
 - a. Wandering
 - b. Poor self-care
 - c. Restlessness
 - d. Impaired memory
 - e. Anxiety
 - f. Depression
 - g. Insomnia
 - h. Unsociability
 - i. Indifference to surroundings
 - j. Fidgeting
 - k. Nervousness
 - l. Uncooperativeness
 - m. Agitated behaviors that DO NOT represent a danger to the resident or others.

Revised 01/15

PHYSICAL RESTRAINT USE/EVALUATION

Purpose:

The purpose of this procedure enables this facility to utilize physical restraints only when alternative interventions to protect the resident's safety have been exhausted, or when the resident has been determined to have the presence of a specific medical symptom that requires the use of a restraint to protect the resident's safety and assists the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. The use of physical restraints will be evaluated on a continual basis and by the Physical Restraint/Reduction committee quarterly in conjunction with the resident's MPS schedule.

Pre-restraining

1. Prior to the implementation of a restraint (which includes but is not limited to lap belts) full lap trays that the resident cannot remove easily, geri chairs, merry walkers, bilateral full side rails, full side rail + wall, leg restraints, arm restraints, hand mitts, lap cushions, wheelchair cushions that prevent rising,) the following interventions should be considered, attempted, and documented as appropriate.
 - a) Consult with the RN Manager, and other nursing and facility staff, as appropriate.
 - b) Determine if the problem may be caused by:
 - i. Resident's hunger.
 - ii. Resident being too hot/cold.
 - iii. Resident's need to go to the bathroom.
 - iv. Resident looking for someone/something.
 - v. Resident's pain or other medical symptom, i.e., delirium r/t illness such as UTI.
 - c) Need for closer supervision such as:
 - i. Move resident's room closer to the nurses' station.
 - ii. Sit resident at nurses' station or with staff members and engage resident in activities of interest to the resident.
 - iii. Involve resident in planned activity/social services/pastoral groups as appropriate.
 - iv. Increase frequency of rounds and visual checks.
 - d) Positioning device needed such as:
 - i. Sitting on a couch or in a comfortable chair
 - ii. Gel cushion in a wheelchair
 - iii. Non-skid mat on wheelchair seat
 - iv. Use of lateral supports in wheelchair
 - v. Use of pillows in bed or elevating head/feet.
 - vi. Use of non-skid mat on floor or non-skid socks
 - vii. Referral to OT/PT for seating/positioning
 - e) Need for exercise such as:
 - i. Take resident for walk inside/outside of facility.
 - ii. Ambulate as appropriate.
 - iii. PT/OT evaluation for strengthening or ambulation program

- f) Safety devices such as:
 - i. Visual reminders (flowers at the door, night light, slop signs, yellow tape, etc.)
 - ii. Low bed
 - iii. Cushion on floor by bedside
 - iv. Motion alarms (tag alarms, bed and/or chair alarms)
 - v. Use of watch guard or other safety system
- g) Adjust care routines such as:
 - i. Change roommates.
 - ii. Change environmental temperature.
 - iii. Change mealtimes or offer routine snacks.
 - iv. Change bath times/dates.
 - v. Change caregivers.
 - vi. Nursing to evaluate the need for a Bowel/Bladder retraining program, or scheduled toileting program, refer to Restorative as appropriate.

The results of these interventions should also be documented on the resident's Pre-restraining Interventions form.

Restraint Utilization

2. If the above interventions are unsuccessful, restraints may be considered, using the least restrictive, most appropriate restraints. "Physical restraint" is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Utilize the following steps when considering the TRIAL of or when establishing the use of a physical restraint. (NOTE: During normal business hours, a physical restraint will be implemented only after review by the Physical Restraint/Reduction Review Committee. During off-hours such as evenings, weekends, holidays, a physical restraint will only be implemented after contacting and reviewing need for restraint with the DNS or the RN Manager.)
 - a) Complete the Pre-restraining Assessment in P.C.C
 - b) Refer the resident to the Physical Restraint/Reduction Review Committee.
 - c) Social Services to obtain signed Consent Form for the specified restraint from resident or legal representative for health care issues.
 - d) Verbal consent for restraint to be obtained from the resident or his or her legal representative PRIOR to the implementation of the physical restraint, by the licensed staff member who obtained the physician's order for the restraint. Verbal consent must be documented in the clinical record.
 - e) Obtain physician statement related to the medical necessity for use of a physical restraint(s).
 - f) Obtain physician order to include:
 - i. Type of restraint - be specific.
 - ii. Reason for restraint use.
 - iii. Times restraint is to be applied/released (physical) (e.g. lap belt on resident while in wheelchair, check q 30 min. release q 2 hours to offer fluids, toilet,

ROM or bilateral full side rails up when resident is in bed, check q 30 minutes, release q 2 hours to offer fluids, toilet, ambulate).

- g) Establish care plan for use of the restraint. (May utilize the Temporary Care Plan for Restraint Use form.)
- h) Reflect use of the restraint including type, when to be placed on the resident, etc., on the CNA kiosk as appropriate.

Restraint Elimination

3. All residents using a “physical restraint” will be continually assessed for possible restraint reduction, as appropriate.
4. Each quarter in conjunction with the MDS schedule and PRN as necessary, the assigned staff shall complete the Physical Restraint Elimination Assessment in Point Click Care and resident will be evaluated by the Physical Restraint/Reduction Review Committee for a physical restraint reduction program implementation.
5. The nursing staff on each unit in conjunction with the committee recommendations, shall implement the restraint elimination interventions.
6. The following documentation will be completed during the physical restraint elimination or change of a physical restraint process:
 - a) Pre-restraining and restraint reduction interventions will be documented on the designated Briggs forms as mentioned above. The forms are to be placed behind the Assessment tab of the resident’s chart.
 - b) Physical restraint reduction or physical restraint changes will be implemented in the resident’s Interdisciplinary care plan (may utilize the Temporary Care Plan form as appropriate).
 - c) Nursing staff caring for the resident involved in a restraint reduction program or change of a physical restraint will be notified through shift report.
 - d) Resident involved in a restraint reduction program or change of a physical restraint will be placed on alert charting.
 - e) The reduction or change of a physical restraint will be indicated/documentated on the kiosk as appropriate.
 - f) Social Services to obtain signed Consent Form for the change in specified restraint from resident or legal representative for health care issues. Verbal consent for restraint to be obtained from the resident or his or her legal representative PRIOR to the implementation of the physical restraint by the licensed staff member who obtained the physician’s order for the restraint. Verbal consent must be documented in the clinical record.
 - g) Residents who received a restraint reduction or change of a physical restraint will be evaluated/followed up at the next scheduled meeting of the Physical Restraint/Reduction Review Committee.
7. In the event of a failed restraint reduction:
 - a) The Staff will notify the Physical Restraint/Reduction Review committee.
 - b) The physical restraint that was reduced will not be re-implemented without following the procedures for Physical Restraint Use/Evaluation,).

Resident Requests for Restraint Use:

8. In the event a resident or his or her legal representative expresses a desire to utilize a physical restraint such as, but not limited to a lap belt or bilateral side rails, prior to implementation the procedures for Physical Restraint Use/Evaluation will be followed as well as:
 - a) The resident or legal representative will be advised regarding the benefits, risks and alternative to the use of the restraint.
 - b) Verify that the resident is cognitively able to make health care decisions (refer to appropriate MDS section).
 - c) The facility per OBRA F Tag 221 may not use restraints in violation of the regulation solely based on a resident, legal surrogate and/or representative's request or approval.
 - d) To implement requested restraint, follow the procedures for Physical Restraint Use/Evaluation.

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PHYSICAL RESTRAINT/REDUCTION REVIEW COMMITTEE

Purpose:

The Physical Restraint/Reduction Review Committee is formed to identify and evaluate the use of physical restraints, to determine appropriate restraint reduction interventions, and to ensure appropriate consents and medical orders are obtained, care plans are updated and all appropriate restraint assessments have been completed.

Committee:

The Committee shall consist of the Director of Nursing Services or designee, Restorative Nurse, MDS Coordinator, an Activities representative, a Social Services representative, and other facility staff as identified.

Procedure:

1. The Director of Nursing Services or designee will establish the time, place, and select any additional participants of the committee.
2. A designated committee member will:
 - a) Determine resident(s) to be evaluated.
 - i. All residents identified as recipients of physical restraints will be reviewed at least quarterly in conjunction with the resident's MDS schedule.
 - ii. All new recommendations for the use of physical restraints will be reviewed.
 - b) Medical record of designated residents who are to be reviewed by the committee will be brought to the meeting by the Licensed Nurse from that resident's nursing unit.
 - c) Maintain a record of all physical restraints by resident/type/unit.
 - d) Be assigned to follow through with all changes as determined by the Physical Restraint/Reduction Review Committee.

Revised 02/15

XII RESTORATIVE

PREVENTING COMPLICATIONS AND DEFORMITIES

Deformities and complications of illness or injury can often be prevented by frequent changes of position, proper positioning in bed and exercise.

Positioning

Purposes for Changing Positions

1. To prevent contractures.
2. To stimulate circulation and to help prevent thrombophlebitis, pressure sores and edema of the extremities.
3. To promote lung expansion and drainage of respiratory secretions.
4. To relieve pressure on a body area.

Principles of Body Alignment in Body Positioning

1. Dorsal or Supine Position
 - a) The head is in line with the spine, both laterally and anteroposteriorly.
 - b) The trunk is positioned so that flexion of the hips is minimized.
 - c) The arms are flexed at the elbows with the hands resting against the lateral abdomen.
 - d) The legs are extended with a small, firm support under the popliteal area.
 - e) The heels are suspended in a space between the mattress and the footboard.
 - f) The toes are pointed straight up.
 - g) Trochanter rolls are placed under the greater trochanters in the hip joint areas.
2. Side-Lying or Lateral Position
 - a) The head is in line with the spine.
 - b) The body is in alignment and is not twisted.
 - c) The uppermost hip joint is slightly forward and supported by a pillow in a position of slight abduction.
 - d) A pillow supports the arm, which is flexed at both the elbow and the shoulder joints.
3. Prone Position
 - a) The head is turned laterally and is in alignment with the rest of the body.
 - b) The arms are abducted and externally rotated at the shoulder joint; the elbows are flexed.
 - c) A small, flat support is placed under the pelvis, extending from the level of the umbilicus to the upper third of the thigh.
 - d) The lower extremities remain in a neutral position.
 - e) The toes are suspended over the edge of the mattress.

THERAPEUTIC EXERCISES

Exercise involves the function of the muscles, nerves, bones and joints as well as the cardiovascular and respiratory systems. The return of function depends on the strength of the musculature that controls the joint.

Objectives

1. To develop and retrain deficient muscles.
2. To restore as much normal movement as possible.
3. To stimulate the functions of various organs and body systems. accomplishments of Exercise

Programs

1. Maintain and build muscle strength.
2. Maintain joint function.
3. Prevent deformity.
4. Retrain for neuromuscular coordination.
5. Stimulate circulation.
6. Build tolerance and endurance.

Type of Exercise

1. Passive: An exercise earned out by the therapist or nurse without assistance from the patient.
 - a) Purpose: To retain as much joint range of motion as possible to maintain circulation.
 - b) Action:
 - i. Stabilize the proximal joint and support the distal part.
 - ii. Move the joint smoothly, slowly and gently through its full range of motion.
 - iii. Avoid producing pain.
2. Active Assistive: An exercise carried out by the patient with the assistance of the therapist or nurse.
 - a) Purpose: To encourage normal muscle function.
 - b) Action:
 - i. Support the distal part and encourage the patient to take the joint actively through its range of motion.
 - ii. Give only the amount of assistance necessary to accomplish the action.
 - iii. Short periods of activity should be followed by adequate rest periods.
3. Active: An exercise accomplished by the patient without assistance.
 - a) Purpose: To increase muscle strength.
 - b) Action:
 - i. When possible, active exercise should be done against gravity.
 - ii. The joint is moved through full range of motion without assistance.
 - iii. The patient should not substitute another joint movement for the one intended.
 - iv. Other active forms of exercise include turning from side to side, turning from back to abdomen and moving up and down in bed.

4. Resistive: An active exercise carried out by the patient working against resistance produced by either manual or mechanical means.
 - a) Purpose: To provide resistance in order to increase muscle power.
 - b) Action:
 - i. The patient moves the joint through its range of motion while the therapist provides slight resistance at first and then progressively increases resistance.
 - ii. 2. Sandbags and weights can be used and are supplied at the distal point of the involved joint.
 - iii. The movements should be done smoothly.

5. Isometric or Muscle-Setting: Alternately contracting and relaxing a muscle while keeping the part in a fixed position. This exercise is performed by the patient.
 - a) Purpose: To maintain strength when a joint is immobilized.
 - b) Action:
 - i. The patient contracts or tightens the muscle as much as possible without moving the joint.
 - ii. He holds for several seconds, then “let’s go” and relaxes.
 - iii. He breathes deeply during the contraction phase.

RANGE-OF-MOTION EXERCISES

Range of motion is the movement of a joint through its full range in all appropriate planes. It may be passive, active or resistive.

Objectives:

1. To maintain function and prevent deterioration.
2. To maintain or increase the maximal motion of a joint.

Underlying Principles

1. Range-of-motion testing is done by the physician to determine the movement that exists at the joint areas. Testing helps set realistic and positive goals.
2. The patient's range of motion is affected by his physical condition, the disease process and his genetic makeup.
3. Each joint of the body has a normal range of motion.
4. Joints may lose their normal range of motion, stiffen and produce a permanent disability; frequently seen in neuromuscular conditions - hemiplegia.
5. Range-of-motion exercises are individually planned since there is wide variation in the degrees of motion of which patients of varying body builds and age groups are capable.
6. Range-of-motion exercises should be carried out whenever there is physical inactivity, provided the patient's clinical status allows such activity.

Techniques of Range of Motion

1. Place patient in a supine position with his arms to the side and the knees extended.
2. Hold the extremity at the joint, e.g., elbow, wrist or knee; and move the joint smoothly, slowly and gently through its range. If the joint is painful (as in arthritis) support the extremity in the muscular area.
3. Move each joint through its range of motion about three times - smoothly, rhythmically and slowly.
4. Avoid moving a joint beyond its free range of motion; avoid forcing movement. The motion should be stopped at the point of pain.
5. When painful muscle spasm is present, move the joint slowly to the point of resistance. Then exert gentle, steady pressure until the muscle relaxes.

Definitions

Abduction	Movement away from the midline of the body.
Adduction	Movement toward the midline of the body.
Flexion	Bending of a joint as the angle of the joint diminishes.
Extension	The return movement from flexion; the joint angle is increased.
Inversion	Movement that turns the sole of the foot inward.
Eversion	Turns the sole of the foot outward.
Dorsiflexion	Flexing or bending the foot toward the leg.
Plantar Flexion	Flexing or bending the foot in the direction of the sole.

Pronation	Rotating the forearm so that the palm of the hand is down.
Supination	Rotating the forearm so that the palm of the hand is up.
Rotation	Turning or movement of a part around its axis. <ul style="list-style-type: none"> ▪ External: Turning outward, away from the center. ▪ Internal: Turning inward, toward the center.

PREVENTING EXTERNAL ROTATION OF HIP

Patients on prolonged bed rest may develop external rotation deformity of the hip. The hip (being a ball-and-socket joint) has a tendency to rotate outward when the patient lies on his back.

Nursing Management

1. To prevent this deformity, use a trochanter roll extending from the crest of the ilium to the mid-thigh when the patient is lying on his back. A trochanter roll serves as a mechanical wedge under the projection of the greater trochanter.
2. Use a foot board when the patient is in the dorsal position.
3. To make a trochanter roll:
 - a) Take both ends of the towel and bring them to the center. The towel is now folded in half with the edges at the center.
 - b) Turn the towel over so that the ends are facing downward.
 - c) Turn the patient on his side with his upper leg flexed.
 - d) Place on side of the towel in the midline of the buttock. The towel should extend from the crest of the ilium to the mid-thigh.
 - e) Then place the patient in a dorsal position with his leg extended.
 - f) Grasp the remaining side of the towel and roll inward in an underneath fashion until the entire roll is well under the patient's buttocks.
 - g) For the larger patient, a draw sheet or a bath blanket may be used.

PREVENTING FOOTDROP

Foot drop (plantar flexion) is a deformity caused by contraction of both the gastrocnemius and the soleus muscles; it may be produced by loss of flexibility of the Achilles tendon.

Causes

1. Prolonged bed rest and lack of exercise.
2. Incorrect positioning in bed.
3. Weight of bedding forcing the toes into plantar flexion (ankle bends in the direction of the sole of the foot).

Clinical Problems

If foot drop continues without correction, the patient will walk on his toes without the heel of his foot touching the ground.

Nursing Management

1. Use a foot board to keep feet at right angles to the legs when the patient is lying on his back.
 - a) Position the feet with the entire plantar surface firmly against the footboard.
 - b) Maintain the legs in a neutral position. Use a trochanter roll.
2. Encourage the patient to flex and extend (curl and stretch) his feet and toes frequently.
3. Have the patient rotate ankles clockwise and counterclockwise several times each hour.

SUPPORTING THE PATIENT IN DAILY SELF-CARE

Activities of Daily Living

Activities of daily living are those self-care activities that must be accomplished each day in order for the patient to care for his own needs and participate in society. They include:

1. Getting in and out of bed (transfers).
2. Personal hygiene.
3. Dressing.
4. Eating.
5. Using a wheelchair (if necessary).
6. Ambulating (when possible).

Patient Objective

To care for himself/herself in his/her daily routine without depending on others.

Role of the Care Giver

To teach, support and supervise patient while he/she performs these activities, getting any devices necessary which may help him/her facilitate these.

Patient Teaching

1. Study each component motion of the desired activity.
2. Ascertain what methods can be used to accomplish the task (example; there are several ways of putting on a given garment.)
3. Determine what the patient can do by watching him perform.
4. Encourage the patient to exercise the muscles used in performing the motions involved in the activity.
5. Select activities that encourage gross functional movements of the upper and lower extremities (e.g., bathing, holding larger objects).
6. Gradually include activities that use finer motions, e.g., buttoning clothes, eating with a spoon.
7. Extend the period of activity as much and as fast as the patient can tolerate.
8. Have the patient perform and practice the activity in a real-life situation.
9. Encourage the patient to perform every activity up to his maximal capabilities within the
10. Framework of his disabilities.
11. Support the patient by giving justifiable praise for effort put forth and for acts accomplished.

ASSISTING THE PATIENT WITH AMBULATION

Transfer Activities

A transfer is the movement of the resident from one piece of furniture or equipment to another (from bed to chair, bed to commode, bed to wheelchair).

Weight-bearing transfers are carried out by patients who have at least one stable lower extremity (hemiplegics, unilateral lower extremity amputees, patients with hip fractures).

Non weight-bearing transfers are done on residents who are unable to assist with transfers at all.

Preparation of Transfers

Objective: To develop ability to raise and move the body in different positions.

1. Technique for Moving Patient to the Edge of the Bed
 - a) Move the patient's head and shoulders toward the edge of the bed.
 - b) Move his/her feet and legs to the edge of bed. (The patient is now in a crescent position giving good range of motion to the lateral trunk muscles).
 - c) Both arms should be placed well under the patient's hips. (Before the next maneuver, staff should tighten or set the muscles of the back and abdomen.)
 - d) Straighten your back while moving the patient toward you.
2. Technique for Sitting the Patient on the Edge of the Bed
 - a) Place one hand under patient's shoulders.
 - b) Instruct the resident to push his/her elbow into the bed while lifting his/her shoulders with one arm and swing his legs over the edge of the bed with the other (gravity pulls the legs downward, which aids in raising the patient's trunk).
3. Technique for Assisting the Patient to Stand
 - a) Make sure the resident has non-slip shoes or socks
 - b) Place the resident's feet well under him/her.
 - c) Face the resident and firmly grasp each side of the rib cage.
 - d) Place staff's knee against one of the resident's knees.
 - e) Rock the resident forward as he/she comes to a standing position. (Staff's knee is pushed against the patient's knee as he/she comes to the standing position.)
 - f) Ensure that the resident's knees are "locked" (full extension) while he/she is standing. (Locking the patient's knees is a safety measure for those patients who are weak or who have been in bed for a period of time.)
 - g) Give the patient enough time to balance himself/herself.
 - h) Pivot the patient, positioning him/her to sit in the chair.

4. Technique for Transfer by Sliding Board

- a) A sliding board (or transfer board) is a polished, lightweight board that is used to bridge the gap between the bed and the chair (or chair and tub, etc.)
- b) When the muscles that the patient uses to lift himself off the bed are not strong enough to overcome the resistance of body weight, use the following maneuver:
 - i. Place one side of the sliding board under the patients buttocks and the other side on the surface of the chair, bed toilet, etc., to which the transfer is being made.
 - ii. Instruct the patient to push up with his hands, to shift his buttocks and to slide across the board to the other surface.

TECHNIQUE FOR WALKING WITH A CANE

Instruct patient as follows:

1. Hold the cane in the hand opposite the affected extremity; i.e., the cane should be used on the good side.
2. Move the cane at the same time the affected leg is moved.
3. Keep the cane fairly close to the body to prevent leaning.
4. When climbing steps:
 - a) Step up on unaffected extremity.
 - b) Then place cane and affected extremity on the step.
 - c) Reverse this procedure for descending steps.
 - d) The strong leg goes up first and comes down last.

HYDRAULIC RESIDENT LIFT

The hydraulic lift may be utilized for resident transfer.

In as much as no two residents are alike, a reasonable amount of caution shall be exercised to establish the most effective management of resident transfers. Resident transfers shall be performed with a minimum of two (2) nursing staff

Bed to Chair

Procedure:

1. Assemble and check equipment and explain procedure to resident.
2. Allow room for maneuvering.
3. Lock wheelchair brakes or secure chair.
4. Position seat sling underneath resident.
5. Refer to appropriate manufacturer's instructions for proper use of equipment.
6. Once resident is securely transferred, all attachments may be released.

Reviewed 02/15, revised 1/2020

HYDROCOLLATOR PACKS

The purpose of the Hydrocollator Packs is to decrease pain in a specific joint.

The Hydrocollator packs can be dispensed by the Physical Therapist or the Restorative Aide.

Procedure:

1. Temperature of the hot pack machine should not exceed 165 degrees Fahrenheit. Water temperature should be tested once a quarter and changed 1 x a month.
2. Pads should be used to cover the hot packs. If the hot packs are too warm for patient comfort, more padding should be used.
3. Hot packs should be placed only on the area designated by the Physical Therapist in the patient's care plan. The area should be checked for redness prior to use, during use, and immediately following treatment.
4. Hot packs should be left on for no more than 20 minutes; no more than 1 time a day.
5. The patient should be supervised at all times while the hot packs are being used.
6. Upon removal of the hot packs, the area should be examined for any redness.

XIII SKILLED NURSING

PERFORMING A BLOOD GLUCOSE TEST

Procedure:

1. Carry meter with supplies to resident's bedside in carrying case provided.
2. Place case on a clean paper towel, unzip and open case.
3. Provide for residents privacy.
4. Wash hands and apply gloves.
5. Place blood glucose meter and supplies on another clean paper towel to provide a clean working surface.
6. Check test strips vial to ensure that it is dated. Test strips are good for 120 days from the day they are opened or after EXP date printed on Test Strip vial label.
7. Remove a new test strip from the vial and re-cap the vial immediately.
8. Insert the test strip contact end (contacts facing up) into the test port.
9. Push the test strip in until it snaps firmly into place. The meter will turn on automatically when test strip is inserted or when "s" button is pressed. The TRUE balance is a no-coding system, which means the meter does not have to be coded to each lot of test strips.
10. Check that the code number blinking on the meter matches the code highlighted on the vial of test strips currently in use.
11. Prepare residents fingertip with an alcohol pad and allow to air dry.
12. Place the end of the single use lancet against the fingertip and release the trigger to obtain a blood sample.
13. While the "Drop" symbol is flashing, apply the blood sample.
14. Touch the blood drop to the sample entry of the strip. The blood will be drawn into the strip automatically.
15. Hold the finger on the test strip sample tip entry until a "beep" is heard. Once beep is heard remove finger from test strip meter is testing.
16. When blood is applied to the test strip, the countdown mode will appear on the screen.
17. The blood glucose result appears after the measurement is completed. The result is displayed in mg/dl. The result with time and date is automatically stored in the meter's memory.
18. Remove used test strip and discard.
19. Sanitize blood glucose machine using a 10:1 bleach solution wipe and let sit for 5 minutes to allow for full disinfection. (Weekly if stored in individual resident rooms)
20. Remove gloves and wash hands.
21. Discard the used lancet in the sharps container.
22. Chart blood glucose results in E-MAR.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- b. CDC, *Sharps Safety for Health Care Settings (Workbook and Teaching Tools)*. (Updated February 11, 2015). <https://www.cdc.gov/sharpsafety/resources.html>.
- c. CDC, *Infection Prevention During Blood Glucose Monitoring*. (Reviewed March 2, 2011). <https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html>

Revised 01/15, 11/18, 4/20

BLOOD GLUCOSE MONITORING SYSTEM - QUALITY ASSURANCE

Purpose:

To validate the performance of the Blood Glucose Monitoring using a solution with a known range of glucose. A control test that is within the acceptable range indicates the user's technique is appropriate and the test strip and meter are functioning properly.

A Quality Control Test should be performed for the following per manufacturer's recommendation:

- Before executing a blood glucose test with the meter for the first time.
- When opening and using a new vial of test strips.
- When the meter is dropped or splashed with liquids.
- Whenever test results are not consistent with symptoms.
- When checking if the system is working properly.
- When practicing testing and checking correct procedure.

Performing a Quality Control Test:

1. Remove a test strip from the vial and recap the vial immediately. If opening a new box of test strips, write the expiration date on the vial. If box has already been opened, check that the expiration date on the vial valid. Test strips are to be used within 3 months of opening.
2. With meter off, insert test strip contact end (contacts facing up) into the test port.
3. Wait until the Drop symbol appears in the display.
4. Open the cap and turn control bottle upside down, squeeze one drop of control onto a clean tissue. Wipe off bottle tip. (swirl or invert control bottle gently to mix – DO NOT SHAKE)
5. Gently squeeze another drop of control onto a small piece of non-porous surface and discard or clean surface used.
6. While Test Strip is in the meter touch edge of Test Strip to drop of control and allow drop to be drawn into Test Strip.
7. When a “beep” is heard, leave the meter on a flat surface while waiting for the test result. The screen will show a countdown mode.
8. Tightly recap the control solution.
9. The control result appears after the measurement is completed. Compare the control test result to the range printed on the test strip vial label. The result should fall within the solution range printed on the label of the test strip vial.
10. If the control solution test results are out of the control solution range there are several possible causes:
 - The machine may not be working correctly
 - Check if control solution is expired or has been open for a duration of over 3 months.
 - Check that the test strips have not expired.

- Check for prolonged exposure of the test strips or control solution due to absence of the cap, incorrect testing procedure or malfunction of the meter.

11. Repeat the Quality Control Test using a new Test Strip. If the control solution tests outside the range again, do not use the machine to test blood glucose. Ask for a replacement.

12. If the result is in range, the Machine can be used for testing blood. Record the result in the Quality Control log.

Revised 02/15, 11/15

QUALITY CONTROL RECORD

Meter Serial Number _____ (7-digit number on Meter label below the bar code) **Note any problems in Troubleshooting section

Date	Time	TEST STRIPS			GLUCOSE CONTROL - LEVEL					GLUCOSE CONTROL - LEVEL		
		LOT	EXP	Date Opened	LOT	EXP	Date Opened	Acceptable Range	Result	LOT	EXP	Date Opened
		On TRUEbalance Test Strip vial label, write date vial opened. Discard vial if either 120 days after opening or after EXP date printed on the vial label has passed.			On TRUE control bottle label, write date bottle opened. Discard bottle if either 3 months after opening or after EXP date printed on the bottle label has passed.			Printed on vial label of Test Strips being used.		On TRUE control bottle label, write date bottle opened. Discard bottle if either 3 months after opening or after EXP date printed on the bottle label has passed.		

TROUBLESHOOTING

Date	Problem	Action

Meter Serial Number _____ (7-digit number on Meter label below the bar code) **Note any problems in Troubleshooting section

Date	Time	TEST STRIPS	GLUCOSE CONTROL - LEVEL	GLUCOSE CONTROL - LEVEL

CARE OF THE RESIDENT AFTER DIALYSIS VASCULAR ACCESS SITE

Purpose:

To provide protocols for caring for the resident following dialysis and management of the vascular access site.

To maintain communication between the dialysis unit and ISVH-P.

Procedure

1. Assess the resident on return from the dialysis unit.
 - a. Primary nurse is to review returned consult form and follow up with any physician orders or special problems encountered during dialysis.
 - b. Monitor resident for changes in weight, vital signs, BP, temperature, pulse, and the respirations.
 - c. Check for bleeding or S/S of infection at vascular site (i.e. erythema, excessive tenderness, swelling, drainage) upon return, 30 minutes after, 1 hour after and then each hour for 3 more hours.
 - d. Make resident comfortable by encouraging loose clothing over the graft arm or leg.
 - e. Do not allow blood pressure or blood sample taken on the graft arm or leg.
 - f. Place a 10 pound restriction for the resident's arm used for the graft.

Revised 02/15

DRESSING CHANGES

Protocol for dressing changes will be as follows:

Sterile technique will be followed post-operatively for all surgical interventions or debridements with appropriate gloving, draping, and disposal techniques. Strict sterile technique for gloving and sterile field will be managed to minimize the possibility of nosocomial infections.

All other dressing changes will follow a modified “clean” technique.

1. Make sure the resident is in a comfortable position, screened to allow privacy and draped to prevent chilling.
2. Wash hands.
3. Establish a clean field, i.e. clean towel, blue pad, or packaging wrapper, to prevent contact with soiled surfaces.
4. Assemble all supplies required for procedure.
5. Open and set up supplies, tear tape, open dressing packages, remove caps from ointments or solutions. Pour onto dressing if required.
6. Protect underlying areas if excess leakage is anticipated, with waterproof drape.
7. Glove.
8. Remove soiled dressing.
9. Holding soiled dressing in one hand, pull that glove over dressing and off hand; repeat with remaining glove, turning inside out and discard in appropriate receptacle.
10. Wash hands and re-glove.
11. Cleanse wound, taking care to work from mid-line out. Do not re-contaminate already cleansed area
12. Apply ointment, cream, or solution using clean applicator (i.e. q-tip, tongue blade or irrigation syringe.)
13. Re-dress.
14. Clean work area, discarding all contaminated materials in appropriate receptacle or double bag if required.
15. Leave unused dressings or supplies at bedside, or discard if contaminated.
16. Ensure that no sharp objects are left in trash or linens that could puncture bags or cause staff injury.
17. Wash hands.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Wound Source, *Wound Chronicity and Infection Prevention and Management*. (February 27, 2018). <https://www.woundsource.com/blog/wound-chronicity-and-infection-strategies-prevention-and-management>

Revised 10/09 Reviewed 02/15, 4/20

FLUID INTAKE

Purpose:

To accurately monitor and document a resident's fluid intake.

Procedure

1. Resident's fluid intake will be monitored and documented as a result of a physician or nursing order.
 - a) The need to monitor a resident's fluid intake is typically the result of an acute illness, signs/symptoms of dehydration, diagnosis of dehydration, abnormal lab values indicative of fluid volume deficit/overload and/or tube feeding.
 - b) Monitoring of fluid intake, unless related to a long-standing tube feeding, will be time limited. (Physician/nursing order should specify time frames.)
2. Fluid intake will be tracked by the certified nursing assistant and/or licensed nurse assigned the resident starting at the beginning of each shift.
 - a) At the end of each shift the aide assigned the resident is responsible for providing the total of the intake to the assigned licensed nurse. The licensed nurse may provide additional input into the shift totals, as appropriate.
 - b) The assigned CNA or licensed nurse is responsible for documenting the intake on the resident's POC medical record. If the resident is a Strict I&O it is the responsibility of the licensed nurse to document.

Revised 01/15

INJECTIONS

Purpose:

To provide safe medication administration, injection safety or safe injection practices are a set of measure taken to perform injections in a manner that is optimally safe for residents, facility staff and others. A safe injection does not harm the recipient, does not expose the provider to any avoidable risks, and does not result in waste that is dangerous for the community (e.g., through inappropriate disposal of injection equipment)

Prior to administration of injectables read labels. All multidose vials labels will be assigned to a specific resident, with a resident label affixed and dated with the open date as well as the maximum beyond-use date 28 days after opened.

Subcutaneous Injections:

1. Medications administered via subcutaneous injection must be ordered via that route/type of injection, verify the resident and medication ordered.
2. Medications typically ordered via subcutaneous injection are insulin and heparin.
3. Subcutaneous injections are typically administered through a 27 gauge needle - tuberculin-type syringe.
4. Gather medication, sterile syringe, alcohol wipes and clean gloves.
5. Practice hand hygiene
6. Apply clean gloves
7. Prepare injection in a designed clean area not adjacent to potential source of contamination, including sinks.
 - a. Disinfecting the rubber septum of medication vial with alcohol before each access.
8. To administer a subcutaneous injection:
 - a. Perform hand hygiene
 - b. Apply clean gloves
 - c. Clean site with alcohol and allow to dry
 - d. Gently raise a fold of skin
 - e. Insert needle at 45-90 degree angle
 - f. Inject medication slowly
 - g. Place alcohol sponge over injection site and quickly withdraw needle
 - h. Do NOT rub injection site
 - i. Discard needle, syringe and possible single dose vial in appropriate receptacle.
 - j. Discard gloves
 - k. Perform hand hygiene.
 - l. Record in medication administration record (EMAR), including site.

Intra-Muscular Injections

1. Medications administered via intra-muscular injection must be ordered via that route/type of injection, verify the resident and medication ordered.
2. Observe if medication is from a single dose or multidose container and administer/dispose/label container accordingly.
3. Medications typically ordered via intra-muscular injection are antibiotics and vaccines.
4. Intra-muscular injections are typically administered through a 1.5 to 3 inch 19 - 23 gauge needle.
5. Sites used are deltoid, ventrogluteal, dorsogluteal, and lateralis muscles.
6. .05-2 mL in deltoid; dorsogluteal, ventrogluteal and lateralis are 4mL, with 5mL cited as the maximum, which is typically administered into one site.

7. Gather medication, sterile syringe, alcohol wipes and clean gloves.
8. Practice hand hygiene
9. Apply clean gloves
10. Prepare injection in a designated clean area not adjacent to potential source of contamination, including sinks.
 - a. Disinfecting the rubber septum of medication vial with alcohol before each access
11. To administer an intra-muscular injection:
 - a. Perform hand hygiene
 - b. Apply clean gloves
 - c. Position resident, select site, and clean site with alcohol sponge.
 - d. Insert needle quickly at 90 degree angle
 - e. Aspirate to see if needle is in a blood vessel. If so, use a new needle and syringe and draw up medication again.
 - f. Withdraw needle quickly while applying pressure with alcohol prep
 - g. Discard needle and syringe in a sharps container or receptacle
 - h. Discard gloves
 - i. Perform hand hygiene
 - j. Record in medication administration record (MAR), including site.
 - k. Update the immunization tab in the EMR if giving vaccinations.
 - l. Observe resident for adverse reactions. If side-effects are present, notify the nurse manager and physician. Document in nurse progress notes.
 - m. Update electronic medical record (EMR) indicating new allergy and reaction.

01/03, updated 3/2019

NEBULIZER/SVN TREATMENTS

Purpose:

1. Nebulizer/SVN treatments will be administered per physician order.
2. Prior to allowing a resident to independently hold/administer a nebulizer treatment a Self Administration of Medications Assessment will be conducted in accordance with established procedure. The assessment will be filed in the resident's medical record and will be reviewed each quarter in conjunction with the resident's RAI schedule.
3. Licensed nursing staff is responsible for dispensing the ordered medication into the nebulizer container.
4. If the resident is capable of holding the nebulizer unit then the nurse shall check back with the resident approximately 15 minutes after the treatment begins.
5. If the resident is unable to hold the nebulizer unit then a face mask-type nebulizer unit shall be considered.

11/09 Reviewed 02/15

CPAP/BIPAP THERAPY - RESPIRATORY CARE

Purpose:

To provide increased oxygenation and improve hemodynamic stability with the use of (NIV) noninvasive ventilation to residents with sleep apnea and/or other compromised respiratory systems.

ISVH-P will follow the manufacturers' recommendations for using and maintaining individual CPAP/BIPAP machines, should their recommendations differ from facility.

Procedure:

1. Explain the procedure to the resident/patient.
2. Assure that the air tubing is connected to the air outlet and the mask.
3. Fill the water chamber with distilled/sterile water.
4. Place the mask on the residents face, assuring a comfortable but snug fit to establish a seal and prevent leakage.
5. To start therapy push start button.
6. All CPAP/BIPAP users will be assessed and approved through the VA to become eligible for the equipment replacement schedule.
7. Replacement schedule: All equipment will be replaced by the VA every six months. At month 5, the charge nurse will contact the VA to order the replacement equipment at (801) 582-1565 extension 2841.
8. Daily washing schedule: mask and cushion with warm soapy water (unless otherwise specified by manufacturer)
9. Weekly washing schedule: wash CPAP/BIPAP/VPAP machine and air tubing with warm soapy water. Soak CPAP/BIPAP/VPAP humidifier chamber in 1 part vinegar to 3 parts water for 20 minutes then thoroughly rinse with hot water and air dry (unless otherwise specified by manufacturer)
10. Replace disposable filter monthly. (unless otherwise specified by the manufacturer)

11. Monthly washing schedule: wash headgear (straps) in laundry fasten velcro down, soak tubing and mask in 1 part vinegar to 3 parts water for 20 minutes then thoroughly rinse with hot water and air dry. (unless otherwise specified by the manufacturer)

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C.F.R. 483.80 (a)(2)(e) and F583- Right to Personal Privacy 583.10 (h)(1).
- b. *How to Clean Your CPAP* <https://www.sleepassociation.org/sleep-treatments/cpap-machines-masks/how-to-clean-your-cpap/>
- c. *CPAP.com Recommended Replacement Schedule*, <https://www.cpap.com/Replace>

Reviewed 02/15, Revised 9/2019

HUMIDIFIERS – RESPIRATORY CARE

Purpose:

To provide moisturized air to a resident's personal area.

Procedure:

1. Obtain an order for humidifier use.
2. Have maintenance inspect the humidifier for safety.
3. Fill the water chamber with distilled / sterile water.
4. To start humidifier push start button.
5. Weekly cleaning procedure:
 - a. Turn off and unplug the humidifier.
 - b. Remove water tank from base.
 - c. Remove mist outlet from top of water tank.
 - d. Remove tank cap, taking care that black rubber cap seal does not come off.
 - e. Empty water from water tank and base.
 - f. Add 2 cups undiluted distilled white vinegar to water tank, replace tank cap and swish vinegar around tank.
 - g. Place tank on base, vinegar will drain into water reservoir.
 - h. Soak for 15-20 minutes.
 - i. After soaking, unlock tank cap and pour solution out into sink.
 - j. Use vinegar from water reservoir to wipe underside of the mist outlet with a clean cloth.
 - k. Pour solution from water reservoir out into sink.
 - l. Wipe nebulizer and float with soft cloth to remove any matter.
 - m. Rinse water reservoir and water tank until vinegar smell and particles are gone. Make sure water does not enter the fan opening (vented opening in back of base or power knob).
6. Weekly Disinfection procedure:
 - a. Turn off and unplug the humidifier.
 - b. Remove water tank from base.
 - c. Remove mist outlet from top of water tank.

- d. Remove tank cap, taking care that black rubber cap seal does not come off.
- e. Empty water from water tank and base.
- f. Add 1 TSP of bleach to 1 gallon of water. (using more than 1 tsp of bleach per gallon of water may result in damage to the humidifier).
- g. Swish bleach water solution around tank.
- h. Place tank on base, bleach water solution will drain into water reservoir.
- i. Soak for 15-20 minutes.
- j. After soaking, unlock tank cap and pour solution out into sink.
- k. Use bleach water solution from water reservoir to wipe underside of the mist outlet with a clean cloth.
- l. Pour solution from water reservoir out in sink.
- m. Wipe nebulizer and float with soft cloth to remove any matter.
- n. Rinse water reservoir and water tank until bleach water solution smell and particles are gone. Make sure water does not enter the fan opening (vented opening in back of base or power knob).
- o. DO NOT MIX VINEGAR AND BLEACH SOLUTIONS TOGETHER.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C.F.R. 483.80 (a)(2)(e) and F583.10 (h)(1).
- b. *Honeywell Ultrasonic Cool Mist Humidifier*,
<https://www.honeywellpluggedin.com/sites/default/files/2018-04/HUL535%20%281%29.pdf>

Developed 1/2020

OXYGEN THERAPY - RESPIRATORY CARE

1. Oxygen is administered appropriately to residents/patients to improve oxygenation and provide comfort to residents experiencing respiratory difficulties.
 - a) Oxygen flow rate is set and administered by licensed staff only; staff delegated and/or the resident, under direction/supervision of the licensed nurse, may apply cannula and turn on concentrator. The licensed staff is to adjust all Oxygen rates per the physician order. (IDAPA 23 – BOARD of NURSING)
 - b) Oxygen administration requires a physician's order.
 - c) In an emergency, a nurse may administer oxygen and obtain an order as soon as able. (See Standing Orders.)
 - d) Humidification is recommended for liter flows greater than 4 liters and for all residents with trachs.
2. Oxygen tanks are kept in the oxygen closet.
3. If supplies are not available, storekeeper may be contacted.
4. Liquid O₂ is typically used when the resident is mobile. Concentrators (for below 5 liters) should be utilized.
5. Signs of oxygen use are painted on doors entering rooms.
6. Cannulas are the preferred equipment unless the resident/patient is a mouth breather.
7. The procedure and safety precautions should be explained to the resident/patient and all caregivers prior to the initial use of Oxygen.
 - a. Procedure: Hands are to be washed before and after procedure per facility protocol.
 - b. Obtain humidification pre-filled bottle.
 - c. Attach the wing nut in the humidifier to the oxygen source.
 - d. Connect supply tubing (cannula or mask) to the small nipple on the humidifier lid. Be sure that all connections are secure.
 - e. Turn on the oxygen source humidifier source to the prescribed liter flow.
 - f. Time and date bottle and tubing.
 - g. Place mask on the face or cannula in nose and adjust for comfort.
 - h. For prevention of ulcers around or on ears apply padding to all cannula oxygen tubing unless otherwise indicated or resident refuses.
 - i. Change masks and cannula as needed and in accordance with the facility's equipment changeover schedule.
 - j. Update resident's care plan as needed.

Revised 01/16

RESUSCITATION

1. Residents, Legal Guardians, and families are encouraged to discuss and explore code/resuscitation decisions with Nursing staff; Social Services, the Physician, Family Nurse Practitioner and/or the Chaplain and complete advanced directives prior to or immediately following admission to the facility.
2. The decision regarding FULL or DNR/DNI CODE status will be clearly delineated in the individual resident's medical record.
3. In the event of cardiac/pulmonary arrest (absence of pulse and respiration and loss of consciousness) the resident's code status will be identified and followed per directive(s).
4. In the event a resident has FULL CODE status and an arrest has been witnessed/diagnosed:
 - a) Nurse, with assistance when possible, initiates CPR immediately.
 - b) 911 is accessed.
 - c) Facility staff contact resident's physician/FNP to relay resident current condition and to obtain further instructions.
5. All potential rescuers are to initiate CPR unless:
 - a. A valid DNR order is in place
 - b. Obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present
 - c. Initiating CPR could cause injury or peril to the rescuer
6. In the event the resident has DNI/IDNR (do not intubate/do not resuscitate) code status, no CPR will be administered following an arrest diagnosis.
7. In the event of a resident's death the Postmortem Procedure shall be followed.
8. All resident assessment and resuscitation/intervention information will be entered in the resident's medical record in the progress note section.

Revised 02/15

TRACHEOSTOMY SUCTIONING

Purpose:

Tracheostomy suctioning is provided to maintain an airway, prevent aspirating from food or secretions and allow for removal of tracheal-bronchial secretions.

Procedure:

26. Explain procedure to resident and provide privacy.
27. Place resident in semi-Fowler's position.
28. If a fenestrated tracheostomy tube is in place, insert a plain inner cannula prior to suctioning.
29. Select catheter. Catheter must be no more than half the internal diameter of the respiratory tube in situ. e.g. Trach tube internal diameter 10mm. (38 gauge) - suction catheter external diameter 4.5mm (14 gauge).
30. Turn on suction pressure gauge, checking that the pressure is between 100-200mm HG.
31. Open suction catheter pack and attach suction port end to the suction tubing, leaving remainder of catheter in protective sleeve.
32. Put on disposable gloves and protective eye cover.
33. Remove catheter from protective sleeve, ensuring that the part of the catheter to be inserted into the trachea remains sterile (do not touch).
34. Lubricate catheter tip with sterile saline while catheter control valve is uncovered.
35. Ask patient to take a couple of deep breaths or deliver extra oxygen for 2 minutes.
36. Observe the patient closely throughout the procedure.
37. With vacuum, control port open insert catheter carefully into tracheostomy tube just past distal end of the tube (approximately 1/3 of the length of the catheter).
38. If resistance is felt, withdraw 1-3cms. (If the catheter rests against the tracheal mucosa it will cause trauma, if it rests against the carina it will stimulate the vagus nerve with the potential for hypotension and cardiac arrhythmia.)
39. Apply suction pressure by occluding the vacuum port.
40. Slowly withdraw the catheter without rotation and within 10 seconds.
41. Allow resident a rest period and replace oxygen or humidified air over tracheostomy.
42. Repeat steps 8-14 not more than once if necessary.
43. Wrap suction catheter around dominant hand and remove glove inside out over catheter.
44. With non-dominant hand, flush suction tubing with water until clear.
45. Remove gloves including catheter and discard into trash, wash hands¹ remove and wash protective eye cover.
46. Chart procedure, amount and nature of secretions, patient's tolerance of procedure.
47. Inform Unit Manager of any adverse reactions.
48. Never allow secretions collecting in suction bottle to exceed 500cc.
49. Discard suction boule into medical waste trash in the soiled utility room.

10/09 Reviewed 02/15

TRACHEOSTOMY CARE

All tracheostomy care is performed by a licensed nurse in response to a physician's order. Tracheostomy care should be performed at least once a day and PRN as needed.

Equipment Preparation:

24. Obtain equipment including sterile tracheostomy tray, sterile normal saline, suction equipment, hydrogen peroxide, scissors, and sterile Q-tips.
25. Wash hands before and after treatment and wear gloves.
26. Open tracheostomy tray that contains:
 - f) sterile gloves
 - g) sterile Q-tips
 - h) plastic basins
 - i) tracheostomy tapes
 - j) wire brush
27. Fill one basin with hydrogen peroxide and another with normal saline.
28. Saturate three Q-tips in hydrogen peroxide and three in normal saline. Place in third empty basin.

Resident Preparation/Procedure:

29. Explain procedure to resident and provide privacy.
30. Place resident in semi-Fowler's position
31. Put on clean gloves.
32. Remove inner cannula and place in hydrogen peroxide and let soak.
33. Suction entire length of outer cannula.
34. Discard used suction catheter.
35. Remove soiled dressing and discard.
36. Remove gloves and put on a set of sterile gloves.
37. Using wire brush, insert it into inner cannula to remove any secretions.
38. Place inner cannula in basin of normal saline to wash off hydrogen peroxide, shake off excess saline.
39. Replace inner cannula and lock in place.
40. Clean around stoma with Q-tips, alternating hydrogen peroxide and normal saline.
41. Using precut tracheostomy dressing, place around tracheostomy.
42. If tracheostomy tapes are soiled, replace them. Cut a slit approximately 1 to 1 ½ inches from end of new tapes. Place tapes through tracheostomy openings and tie before removing soiled tapes.
43. Document in medical record the amount and character of drainage, condition of stoma and skin, and other pertinent observations.
44. Inform Unit Manager of any adverse reactions.

10/09 Reviewed 02/15

URINARY/SUPRAPUBIC UROSTOMY CATHETER INSERTION

1. Catheters (urinary and suprapubic) are ordered by the individual residents primary physician. Orders include catheter size, balloon size, and diagnosis for use.
2. Initial insertion of a suprapubic catheter is done by a physician.
3. Initial insertion of a urinary catheter is done by either a physician or licensed nursing staff.
4. Catheters are inserted using aseptic technique and sterile equipment.
5. Catheters are inserted and maintained in a closed system; the bag should never be changed out by itself.
6. Catheters are only changed as needed related to leaking, occlusion or 48 hours after antibiotic therapy is initiated for a urinary tract infection.

Insertion

1. Obtain proper size catheter, along with syringe and sterile water for balloon inflation and sterile gloves.
2. Explain procedure to resident and provide privacy.
3. Perform hand hygiene, don clean gloves
4. If catheter is to be removed, deflate balloon with a syringe and gently withdraw catheter.
5. Doff clean gloves, perform hand hygiene.
6. Set up sterile field
7. Don sterile gloves.
8. Cleanse abdominal wall (suprapubic) or groin area (urinary) with betadine or the aseptic cleansing product included in the sealed catheter kit. Cleaning from the cleanest areas to the dirtiest areas.
9. For male catheterization:
 - a) Position resident in dorsal recumbent position.
 - b) Clean glans penis by beginning at meatus and proceeding in a circular motion down shaft.
 - c) Lubricate catheter liberally for approximately 6-8 inches.
 - d) Hold penis at right angle from body. Gently insert catheter 6 to 8 inches into urethra until urine flows. Do not force catheter.
10. For female catheterization:
 - a) Place resident in a lithotomy position with knees apart, provide sufficient light.
 - b) b. Separate labia with thumb and forefinger with 1 hand (which becomes the dirty hand) to expose meatus. Clean vulva carefully as not to touch the skin with the clean hand.
11. Insert catheter in opening, advance until urine passes through catheter opening and advance 2 to 3 inches, then inflate balloon with water.
12. Attach to bedside drainage if not already attached. Collection bags should always be kept below the level of the bladder and off the floor. Catheter bags should be covered when resident is out of the privacy of his/her room.
13. If drainage is poor, ensure catheter is not kinked.
14. Empty drainage bag PRN and q shift.
15. Document in the nurse progress notes (or EMAR) the reason for replacement or removal.

References:

- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- d. Centers for Disease Control and Prevention, *Catheter-Associated Urinary Tract Infections (CAUTI)* (Reviewed November 5, 2015). <https://www.cdc.gov/infectioncontrol/guidelines/cauti/>

Reviewed 02/15, Revised 2/14, Revised 4/20

**(P.I.C.C.) CATHETER DRESSING CHANGE
PERIPHERALLY INSERTED CENTRAL CATHETER**

NOTE: P.I.C.C. line dressing will be changed 24 hours after initial insertion of the catheter, unless otherwise indicated by physician, and then every seven days after the insertion. The dressing will be changed more often if it becomes loose, contaminated or the site bleeds.

PROCEDURE:

STEPS	KEY POINTS
1. Explain procedure to the patient and their role in helping to maintain the sterility of the procedure.	1. Encourages cooperation and prevents accidental contamination of the sterile field or equipment.
2. Don face mask and exam (non-sterile) gloves.	2. Reduces transmission of microorganisms; standard precautions (face mask is in first layer of sterile wrap in dressing kit.)
3. Remove old dressing and discard in appropriate receptacle.	3. Exposes the catheter site for inspection and cleansing.
4. Inspect catheter, insertion site and surrounding skin.	4. Detects signs of infection, catheter dislodgement or leakage.
5. Remove non-sterile gloves and discard. Open kit and don sterile gloves provided.	5. Maintain aseptic techniques
6. Utilize the solutions within the kit with swabs provided to cleanse the site. Begin with swabs soaked with hydrogen peroxide at the insertion site using concentric circles; cleanse the skin with one swab at a time.	6. Remove old blood and debris from the site. 6. Outward circular cleansing prevents contamination of the insertion site of the catheter.
7. After dry, cleanse with chlorhexidine swabs, one at a time with back and forth motion.	7. Chlorhexidine is the antimicrobial cleansing agent of choice. 7. Solution reduces the rate of re-colonization of skin microflora.
8. Apply skin protectant to the skin where the edges of the dressing are to be placed.	8. Protects the skin from injury upon removal of tape. Do not apply within 1” of the insertion
9. Take one sterile 2x2 from the kit and place under the winged end of the PICC. Place the second 2 x 2 over the top of the end, tape in place over the middle and lower end of the 2 x	9. Prevents hub from going into skin and creating a pressure sore. Utilize tape as provided in kit for securing gauze into place.

2.	If STAT-LOCK catheter secure device is used, gauze is not needed.
10. Place transparent dressing lengthwise over P.I.C.C. and 2 x 2's. Have the patient hold their arms as straight as possible.	10. Start with the center insertion site and work to edges in placing the dressing. Provides occlusive seal to prevent site contamination. The skin protectant may be utilized to seal the edges of the transparent dressing as it is smoothed in place.
11. Take a piece of medipore tape provided in the kit to seal the tegaderm dressing.	11. Provides a seal at the catheter/skin area to ensure dressing patency around the catheter. Do not excessively tape over the tegaderm or catheter lock device. Prevents catheter dislodgement and/or disconnection.
12. Place date and initial dressing change onto tape.	12. Provides easy check to when the next change is due by any nurse checking the site.
13. Remove and discard gloves and supplies from kit.	13. Standard precautions.
14. Wash hands.	14. Reduces the transmission of microorganisms at site.
15. Document the procedure in the patient's E-MAR under "IV Site Care"	15. Provides record of nursing care, patient response, assessment and outcome.
16. Document any unusual appearance (redness, drainage or tenderness).	16. Signs may be noting an infectious process occurring at insert site.
17. Charge for supplies used for procedure.	17. Utilize patient charge sheet.

NOTE:

If an extension tubing is not connected directly to the catheter, it should be changed every seven days prime. The antimicrobial lock cap will also be changed with the dressing change or more often if frequent access of lock cap is done.

Revised 02/15

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XIV INTRAVENOUS THERAPY

IV FLUID ADMINISTRATION

Intravenous therapy used for hydration or medication therapy should be administered using a pump system to provide accurate infusion and to provide the resident from fluid volume overload related to rapid IV fluid infusion.

Labeling:

All IV medications will be labeled with:

1. Name, address and phone number of dispensing pharmacy
2. Full name of resident
3. Name of prescriber/physician
4. Dispense date.
5. Prescription number
6. Name of medication
7. Name of primary solution
8. Volume dispensed
9. Directions for use including frequency, and duration of administration.
10. Storage requirements
11. Expiration date.
12. Pharmacist's initials.

All IV fluids and tubing will be labeled with:

1. Date and time put into use
2. Initials of nurse hanging fluids and tubing.

Continuous/Intermittent IV Fluid Administration:

1. IV solutions will not hang longer than 24 hours. Discard any remaining solution.
2. IV tubing used for continuous infusion will be changed every 48-72 hours.
3. IV "add on" devices (e.g. extension tubing, filters, etc.) will be considered part of the primary tubing. Otherwise it will be considered intermittent and changed every 24 hours.

Revised 01/15, 4/19

IV PUSH/BOLUS

Any medication being considered for IV push use needs to be evaluated in terms of appropriateness for administration in the long-term care setting. Some drug classifications have an increased risk of cardiac, respiratory, and other side effects.

1. A physician's order is required for IV push administration.
2. Only qualified RNs may administer IV push medications.
3. The qualified RN administering the drug must have thorough knowledge of the drug, rate of administration, as well as the potential complications involved in giving medication via this route.
4. RNs should assess and recommend other modes of administration if available.
5. A resident's drug allergies must be evaluated before administration.
6. Perform hand hygiene and don gloves
7. Cleanse the hub by scrubbing with alcohol wipe for 10-15 seconds.
8. Flush with prefilled 10mL normal saline to establish line patency.
9. Push the medication according to the prescribed rate, once completed flush the line with a prefilled 10 mL normal saline *at the prescribed rate for the medication push* (assuring the remaining medication in the line is administered at the prescribed rate).
10. Cleanse the hub by scrubbing with alcohol wipe for 10-15 seconds and replace the antimicrobial cap.
11. Remove gloves and perform hand hygiene.
12. The resident will be monitored closely the infusion. The medication will be terminated and physician notified immediately if any untoward reaction occurs.

Revised 01/15, 04/19

IV SITE ASSESSMENT

Purpose:

To prevent and monitor for infections related to IV line placement.

Assessment of the IV site will be done prior to and during (periodically for continuous IV fluids) infusion of any fluid, flush, or medication. Assessment will be documented every day and evening shift in the ETAR using the PICC line dressing assessment and PICC line site assessment notes.

Assessment will include evaluation for:

1. Change in resident's normal skin color, swelling or exudates. Slight swelling or redness are indicative of early phlebitis or infiltration. Exudate is a sign of infection. Site should be changed.
2. Leakage of fluid at the IV insertion site. If leakage is from the connection, tighten it. If leakage is from a cracked catheter, site should be changed.
3. Bleeding at the site. If leakage is from the connection, tighten it. If leakage is from a cracked catheter, site should be changed.
4. Condition of the dressing (e.g. wet, soiled or loose). Redress site as appropriate.
5. Warmth, coolness, hardness or complaint of discomfort on or above IV site. (May indicate phlebitis and infiltration.) If any of these conditions are found, restart as soon as possible, apply warm, moist heat to affected area.

CHANGING IV SITE INJECTION CAP

Purpose:

The catheter injection cap is the only part of the system that will need to be changed. The injection cap is used for access and therefore needs to be changed regularly. The frequency will depend on how often the catheter is being used. The catheter injection cap will be changed at least every 7 days along with the dressing change and no more often than 72 hours, unless contaminated.

Lines that typically require the injection cap to be changed are long-standing such as P.I.C.C., central and subclavian lines.

Supplies:

- One sterile injection cap for each line to be changed
 - At least one alcohol wipe per line to be changed
 - At least one Pre-filled Normal saline 10 mL syringe per line to be flushed and changed
1. Wash hands thoroughly.
 2. Put on clean or sterile gloves.
 3. Prepare injection caps according to the instructions.
 4. Unscrew one of the old injection caps and discard, holding the catheter adapter below the level of the heart.
 5. Using alcohol wipe, clean around the hub (10-15 seconds) where the injection cap was connected to the catheter. (Make sure to not touch the inside of the catheter.) Allow to air dry.
 6. Flush the line with prefilled syringe with normal saline leaving the syringe on the end.
 7. Using alcohol wipe, clean around the hub (10-15 seconds) where the injection cap was connected to the catheter. (Make sure to not touch the inside of the catheter.) Allow to air dry.
 8. Pick up the new pre-filled injection cap only by the top. Attach the new injection cap by firmly screwing it onto the catheter hub and flush line if indicated.
 9. Repeat the process for the all the caps.
 10. Document interventions on E-TAR as appropriate.

01/15, 04/19

PERIPHERAL IV CATHETER

Policy:

- IV catheter is inserted by a physician or by a registered nurse (RN) or Licensed Practical Nurse (LPN).
- IV catheter must be ordered by a physician or advanced practice registered nurse (APRN)
- Maintenance and discontinuation of IV access are don by RN's or LPN's.
- Transparent semipermeable (FSM) dressing shall be changed every 72 hours with site rotation. The nurse shall designate on the dressing, the date and time of the insertion and initial.
- Veins in the arm of a resident who has undergone mastectomy or axillary node resection should be avoided. A physician's order is required.

Procedure:

1. RNs and may insert peripheral IV devices.
2. Insertion of a venous access device will be done only on the order of a physician.
3. The nurse shall not make more than 3 attempts to establish an IV line.
4. A new catheter shall be utilized for each attempt.
5. Universal precautions shall be maintained throughout the insertion procedure.
6. Use of lower extremities requires a physician's order and is not recommended.
7. The smallest gauge, shortest catheter that will accommodate the therapy should be used. In the geriatric population, this typically will be a 22 or 24 gauge catheter.
8. The most appropriate vein shall be used starting with the distal area of the upper extremities.
9. The stylet shall never be inserted.
10. Transparent semipermeable (FSM) dressing shall be changed every 72 hours with site rotation. The nurse shall designate on the dressing, the date and time of the insertion and initial.
11. Veins in the arm of a resident who has undergone mastectomy or axillary node resection should be avoided. A physician's order is required.

07/02, Revised 08/04, 04/19

PERIPHERAL IV CATHETER REMOVAL

A peripheral device will be removed upon any of the following conditions:

1. A physician's order.
2. Evidence of infiltration, phlebitis, leaking, infection, or other abnormalities.
3. Complaints of pain.
4. Duration of three days or longer.
5. The following procedure will be utilized:
 - a. Clamp IV tubing if resident has continuous infusion.
 - b. Stabilize catheter by pressing on it with one hand while gently stretching and peeling transparent dressing with the other. Remove dressing.
 - c. Inspect site for complications.
 - d. Gently remove IV device from the vein and inspect the IV catheter.
 - e. Apply a folded, sterile 2x2 to the site, exerting gentle pressure for at least one minute. Elevate extremity slightly when able. Secure gauze firmly with tape or Coban.
6. Document removal in PCC, in a Nursing Progress Note including:
 - a) Date and time.
 - b) Site assessment and location.
 - c) Condition of catheter upon removal.
 - d) Reason for removal of catheter.
 - e) Resident tolerance of the procedure.

Revised 01/15, 04/19

PERIPHERAL INSERTED CENTRAL CATHETER (PICC)

Policy:

- PICC/CVC IV catheter is inserted by a physician or advanced practice registered nurse (APRN) where resident can be monitored for side effects.
- Maintenance of PICC IV access are done by RN's or LPNs. Discontinuation of PICC IV access are done by RN's.
- Discontinuation of PICC IV access are done by RN's
- Notes by the RN responsible for the resident's care, and a physician/APRN order is obtained to maintain site for as long as necessary.
- Site is checked every day and evening shift and as necessary and documented on the ETAR using the PICC line dressing assessment and PICC line site assessment notes.
- Dressing change for transparent dressing should be completed every 7 days and for gauze dressing should be completed every 2 days, to be completed by charge nurse or RN. When scheduled in EMAR Nurse on the hall will notify Charge RN when it is due.
- The venous flushes are to be documented on the EMAR.

Procedures:

1. Access PICC line and flush with 10 mL saline to assure patency of line.
2. Administration is attached with tubing (sterile and <24 hours opened). If there is a question as to sterility, a new tubing will be obtained.
3. Administer medication per prescription.
4. Once completed use a pre-filled normal Saline 10 mL (flush).
5. Lock is to be changed every week, a new cap should be used at least every 7 days but not more than every 72 hours.

Maintenance:

1. Every shift access IV device, swab with alcohol, insert syringe, and inject 10mL of normal saline so that entire catheter and access device are flushed.
2. Check for infiltration.
3. Document on the PCC EMAR.

Updated June 2017, revised 04/19

OCCLUDED PICC LINE

Purpose:

Standard PICC line maintenance will assist in maintaining a patent line. Should a PICC line become occluded as evidenced by an inability to aspirate blood, standing orders for occlusion should be initiated.

RSO Occluded PICC line:

1. Instill 2mg of Cathflo Activase into occluded catheter, do not force solution into catheter.
2. After a 30-minute dwell time, assess catheter function by attempting to aspirate blood.
3. If catheter is functional, aspirate 4 to 5 mL of blood to remove the Cathflo Activase and residual clots and gently irrigate the catheter with a prefilled 10mL syringe of normal saline.
4. If catheter remains occluded allow Cathflo Activase to dwell for another 90 minutes, then attempt again to aspirate blood.
5. If the catheter remains occluded after the total 120-minutes contact the physician for further instruction.

04/19

XV COVID-19 PANDEMIC

COVID-19 PROCEDURE POCATELLO

- A. The best way to prevent COVID-19, is to avoid being exposed to this virus.
 - a. Avoid close contact with people who are showing symptoms of COVID-19 or areas with COVID-19 diagnosed in the community.
 - b. Avoid touching your eyes, nose, and mouth. DON'T TOUCH THE T-ZONE
 - c. Stay home when you are sick.
 - d. Cover your cough or sneeze with a tissue into your elbow. If using a tissue throw the tissue in the trash, IMMEDIATELY PERFORM HAND HYGIENE.
 - e. Avoid crowds or people showing signs/symptoms of respiratory infections (coughing/sore throat/fever/shortness of breath)
 - f. Practice social distancing, greater than 6 feet.
 - g. Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
 - h. **Practice hand hygiene!**
 - i. Wash your hands often with soap and water for at least 20 seconds and completely dry, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
 - ii. Use hand sanitizer (containing at least 60% alcohol) frequently covering all surfaces and allow to completely dry.
- B. Procedures for preventing resident exposure to COVID-19
 - a. Doors between highly protected resident care area will be kept closed
 - b. Resident who are not assessed as a choking risk will eat meals in their rooms
 - c. Residents who are assessed as a choking risk will eat meals in the south hall dining area maintaining >6 feet apart.
 - d. Resident off site activities are postponed until after COVID-19 threat
 - e. During resident on site activities >6 feet will be maintained.
 - f. Once positive COVID-19 case has been identified with in the community staff will wear surgical mask when in the facility.
 - g. Once community transmission is identified, staff will implement universal use of facemask, consider having HCP wear recommended PPE or facility-maintained clothing to reduce transmission into the facility.
- C. Procedures during COVID-19 pandemic
 - a. Doors granting entry to the facility are currently locked.

- b. All persons coming into ISVH-P will be screened. This includes but is not limited to staff/contractors/visitors.
 - i. Staff/contractor/provider/vendor screening will be done prior to entering the facility, including questioning and temperature assessment.
- c. Visitors are restricted to end of life family members only (limit 2-3 family at a time) all visitors must perform hand hygiene, wear PPE (gown/gloves/mask), the visit should be held in the canteen unless the resident is unable to be transported then the visit can take place in their room under the same precautions, (limit 2-3 family at a time) all visitors must wear PPE (gown/gloves/mask), and hand hygiene
- d. Volunteers, **vendors and hospice ancillary staff** are restricted from entering our facility.
- e. Hospice nurses will utilize telemed for residents.
- f. Director of Medical – Providers will utilize telemed for residents.
- g. Resident will be monitored daily the left halls will be done by day shift medication nurse and the right halls will be done by the evening shift medication nurse
 - i. All residents will be monitored for vitals including pulse ox through the MAR.
 - ii. All residents will have a completed INFECTION SCREENING ASSESSMENT daily in the assessment tab in PCC.

Home Admin Clinical QIA Insights IRM Reports

ISVH - INFECTION SCREENING

Resident: ADAMS, RAYMOND (006213)
 Description: Other
 Date: 3/12/2020 14:20
 Section Status: Unedited
 Lock Date:

SECTION Cust. ISVH - INFECTION SCREENING

Infection Screening	<p>1. Does the resident have any of the following symptoms <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. Temperature at or above 100.4 <input type="checkbox"/> 2. New/Acute cough <input type="checkbox"/> 3. New shortness of breath/Difficulty breathing <input type="checkbox"/> 4. Acute wheezing <input type="checkbox"/> 5. Sore throat <input type="checkbox"/> 6. None of the above <p>2. If any of the above have been noted, please indicate all actions taken (ex: Alert Charting, Notifying of MD/DNS/RNM/Family/Infection Preventionist <input type="checkbox"/></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
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- D. Procedure for a Resident with signs or symptoms of a respiratory infection:
 - a. All Residents **with signs or symptoms of respiratory infection (fever/cough/shortness of breath or sore throat)** will be on **droplet precautions (face masks, gowns, gloves, signage on doors)** until symptoms resolve, orders placed in PCC
 - b. If an unexpected cluster of respiratory infections is noted, IP nurse, Administrator and Southeastern Idaho Public Health Department must be notified.
- E. Procedure for Admissions and Readmissions:
 - a. All new admissions **without signs or symptoms of respiratory infection (fever/cough/shortness of breath or sore throat)** will be Quarantined in their rooms for 14 days to assess for COVID-19, orders with date placed in PCC

- b. All new admissions **with signs or symptoms of respiratory infection (fever/cough/shortness of breath or sore throat)** will be Quarantined in their rooms maintaining **droplet precautions (face masks, gowns, gloves, signage on doors)** until symptoms resolve orders placed in PCC
- c. Add an order for obtaining vitals including pulse ox, there is a template, just start typing infection screening and below is what appears. This will be done **daily for residents without** and **twice daily for residents with signs and symptoms respiratory infections.**
- d. All residents admitted to the left side of the hall should be scheduled for dayshift and those admitted to the right side of the hall should be scheduled for evening shift.
- e. All resident admitted **without signs or symptoms of respiratory infection (fever/cough/shortness of breath or sore throat)** will have a Infection Assessment done daily during the dayshift if their room is on the left side of the hallway and during the evening shift if their room is on the right side of the hallway.
- F. Procedure for Infection screening residents **without** a suspected or confirmed case of COVID-19 at ISCH-P.
 - a. Vitals including pulse ox, will be done **daily for residents without signs or symptoms of respiratory infections** and **twice daily for residents with signs and symptoms respiratory infections.** This is located in the MAR. An Infection Assessment must be completed **daily for residents without signs or symptoms of respiratory infections** and **twice daily for residents with signs and symptoms respiratory infections.**
 - b. For residents only receiving infection screening protocol the left side of the hall should be scheduled for dayshift and those on the right side of the hall should be scheduled for evening shift.
- G. Procedure for infection screening residents **with** a suspected or confirmed case of COVID-19 at ISCH-P.
 - a. Southeastern Idaho Public Health, Central Support, Administrator, DNS, IP nurse and VA will be contacted to notify positive COVID-19 status.
 - b. Residents will be in a single room if possible, if not possible residents may cohort with a similarly COVID-19 positive resident.
 - c. Order will be written for Modified Airborne Isolation precautions.
 - i. Door to resident room to remain closed, air scrubber if available will be in place and operating at all times.
 - ii. Posting to outside of the door specifying Airborne Isolation Precautions (see attached) and the donning/doffing personal protective equipment (PPE) procedural visual aid should be placed near the PPE (see attached).
 - iii. Paper tray service and isolation dedicated vital assessment equipment will be used.
 - iv. PPE includes goggles, N95 (or CDC accepted rebreather), gown and gloves.
 - v. Hand hygiene performed prior to donning and after doffing PPE and proper donning and doffing followed to minimize contamination.
 - vi. PPE will be monitored regularly, should we experience a shortage of PPE the CDC recommendations will be followed for conventional capacity, conserving capacity and crisis capacity.
 - d. Vitals including pulse ox, this is located in the MAR and will be done at least **twice daily for all residents.**
 - e. All residents will have an Infection Assessment at least **twice daily.**
 - f. Additional monitoring may be needed for those with suspected or confirmed COVID-19 as their condition can change rapidly.

Order Details

Order Date: 3/17/2020 08 19 *

Order Category: Other *

Communication Method: Phone Verbal Prescriber written Prescriber entered *

Ordered By: * Last prescribed by: Blaine Olsen
(Current Primary Physician: Blaine Olsen)

Order Template Search: ISVH - Infection Screening clear

Order Template: ISVH - Infection Screening

Description: Obtain temperature and complete ISVH - INFECTION SCREENING ASSESSMENT *

Order Type: Other Orders - MAR - [MAR] *

Scheduling Details

Add Schedule:

Routine 1

Frequency: every evening shift *

Schedule Type: Everyday *

- H. Procedure for Residents with suspected COVID-19
- Southeastern Idaho Public Health, Central Support, Administrator, DNS, IP nurse, local CMS and VA will be contacted to notify positive COVID-19 status.
 - Residents will be in a single room if possible, if not possible residents may cohort with a similarly COVID-19 positive resident.
 - Order will be written for Modified Airborne Isolation precautions.
 - Door to resident room to remain closed, air scrubber if available will be in place and operating at all times.
 - Posting to outside of the door specifying Airborne Isolation Precautions (see attached) and the donning/doffing personal protective equipment (PPE) procedural visual aid should be placed near the PPE (see attached).
 - Paper tray service and isolation dedicated vital assessment equipment will be used.
 - PPE includes goggles, N95 (or CDC accepted rebreather), gown and gloves.
 - Hand hygiene performed prior to donning and after doffing PPE and proper donning and doffing followed to minimize contamination.
 - PPE will be monitored regularly, should we experience a shortage of PPE the CDC recommendations will be followed for conventional capacity, conserving capacity and crisis capacity.
 - Vitals including pulse ox, this is located in the MAR and will be done at least **twice daily for all residents**.
 - All residents will have an Infection Assessment at least **three times daily**.

- f. Additional monitoring may be needed for those with suspected or confirmed COVID-19 as their condition can change rapidly.
- g. PPE procedure for staff assisting resident until transport must include:
 - i. Perform hand hygiene
 - ii. Apply gown
 - iii. Apply N-95 rebreather pinching the adjustable nose clip for a tight fit
 - iv. Apply eye protection
 - v. Apply clean non-sterile gloves
- h. Prior to leaving patient area:
 - i. Remove gloves
 - ii. Remove gown
 - iii. Remove eye protection
 - iv. Remove N-95 rebreather
 - v. Perform hand hygiene
- I. Procedure for Residents with diagnosed or suspected COVID-19 needing transport to PMC, they require a higher level of care than we can provide.
 - a. Contact PMC and ambulance transport provider indicate resident is suspected to have COVID-19 and needs transport to via ambulance.
 - b. Contact Administrator, DNS, IP nurse.
 - c. Follow discharge procedure.
 - d. Resident will be maintained in a private room with the door closed while waiting transport to the hospital via urgent/ambulance transport.
 - e. Use only disposable/single use items for resident until transport
 - f. Only essential staff will have contact with resident, no staff with autoimmune diseases or treatments which compromise their immunity should provide cares or be in the room with the resident.
 - g. PPE procedure for staff assisting resident until transport must include:
 - i. Perform hand hygiene
 - ii. Apply gown
 - iii. Apply N-95 rebreather pinching the adjustable nose clip for a tight fit
 - iv. Apply eye protection
 - v. Apply clean non-sterile gloves
 - h. Prior to leaving patient area:
 - i. Remove gloves
 - ii. Remove gown
 - iii. Remove eye protection
 - iv. Remove N-95 rebreather
 - v. Perform hand hygiene

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Healthy and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Disease Control and Prevention, Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- c. Centers for Disease Control and Prevention, *Coronavirus Disease 2019* <https://www.cdc.gov/coronavirus/2019-ncov/index.html>

d. Centers for Disease Control and Prevention, *COVID-19* <https://www.cdc.gov/coronavirus/2019-ncov/index.html>

Developed/Revised 3/4/2020-3/30/2020

COVID-19 SUSPECTED OR CONFIRMED CASE MANAGEMENT

Purpose:

To provide best practice care for suspected or confirmed COVID-19 positive cases while limiting other residents and staff from exposure risks.

A portion of West hall is designated as the COVID-19 wing. This will include the last 4 rooms, repurposed physical therapy room and repurposed activity room. All necessary Activity supplies have been relocated to the former resident dining room and all necessary physical therapy equipment have been moved to the chapel.

A. Maintaining separation of the COVID-19 Wing

- a. Plastic barrier will be secured after the doorway of from 105 and 113 completely sealing the hallway off from the rest of the facility.
- b. All staff, resident and materials (linens, nutrition, fluids, medication, equipment, etc.) will be brought in through the outside doors.
- c. The former Activity room will be utilized as the "clean room" where staff will be provided an area of respite furnished with chairs, table, refrigerator, stove, sink, stove and microwave. **The clean room door will always remain closed.** Staff reporting for shift will enter through the outside clean room door.
- d. The hallway outside the former Activity room which will now be referred to as the clean room from the cleanroom door to the entrance of the COVID-19 West Hallway will be the intermediate area where staff will don all PPE utilizing the buddy system (whenever possible) and the dirty area where staff will doff all PPE utilizing the buddy system (whenever possible). The clean side on the tiled area, the dirty side will have appropriate waste binds and hand hygiene station for the removal of PPE on the carpeted side.
- e. There will be a openable physical barrier between the intermediate area and the COVID-19 exposure area which is at the entrance of the West Hallway.
- f. The repurposed physical room will act as the supply area and nurses' stations.
 - i. This room will house the following items: clean linens, medication cart, computers, resident care supplies, resident nutritional refrigerator, etc.

B. Procedures for Resident exposed to or suspected or positive for COVID-19

- a. The affected or exposed residents will remain in his room with the door closed.
- b. Provider, Administrator, DNS and Infection Control nurse notified.
- c. Crisis communication plan will be initiated to assure all residents, resident families and authorities are notified (see attached).

- d. Prior to moving exposed residents to the COVID-19 West Hall:
 - i. staff will retrieve Modified Airborne PPE for COVID-19 staff and surgical masks for residents.
 - ii. All available staff will clear all the community areas that they will pass through to move resident(s) to the West Hall.
 - iii. Resident exposed to, suspected or positive for COVID-19 will wear a surgical mask during transfer to the COVID-19 unit.
 - e. Considerations for moving residents with suspected or confirmed COVID-19.
 - i. Staff will isolate the suspected or positive resident in single rooms if possible.
 - ii. Staff will consider moving other residents with which the initial resident has had close contact (within 6 feet for more than 10 minutes). Examples include but are not limited to: roommate, bathroom mates and if the initial resident eats in the South Hall related to eating assistance or choking risk consider moving table mates to the COVID-19 unit.
 - f. Order will be written for Modified Airborne Isolation precautions.
 - i. Posting on all outside entrances and plastic barrier between the COVID-19 and nonCOVID-19 facility stating authorized staff only Modified Airborne Precautions.
 - ii. Paper tray service notification for all residents provided to dietary.
 - iii. Dedicated vitals equipment for CPVOD-19 residents will be placed and maintained on the COVID-19 Unit.
 - g. Move these residents with as little personal effects as possible to their new room on the COVID-19 unit.
 - h. Once in their new rooms, doors will be remained closed for the duration of their illness or investigation of the exposure.
 - i. Visitors are restricted to end of life family members only (limit 2-3 family at a time) all visitors must perform hand hygiene, wear PPE (gown/gloves/mask).
 - i. Visitors will be asked to monitor for signs and symptoms of respiratory infection including temperature (twice daily) and report any symptoms to the Infection Prevention Nurse (208) 643-2740.
 - j. Continuation of hospice nurses and providers to utilize tele-med for residents.
 - k. Continuation of Director of Medical – Providers to utilize tele-med for residents.
- C. PPE will be donned and doffed using the buddy system to assist in monitoring each staff to limit self-inoculation. PPE procedure for staff assisting resident must include:**
- i. Perform hand hygiene
 - ii. Apply gown
 - iii. Apply N-95 rebreather pinching the adjustable nose clip for a tight fit, must wear gloves.
 - iv. Perform User Seal Checks. *to avoid self-inoculation hand hygiene and donning/doffing gloves must be used for this procedure. *
 - 1. Positive Pressure seal check:
 - a. don clean non-sterile gloves
 - b. apply rebreather
 - c. exhale gently while blocking the paths for air to exit
 - d. During a successful check the facepiece is slightly pressurized before increased pressure causes outward leakage.
 - 2. Negative pressure user seal check.
 - a. With clean non-sterile gloves still in place
 - b. Inhale sharply while blocking the paths for air to enter the facepiece.

- c. During a successful check the facepiece will either collapse slightly or pull tight to face under the negative pressure.
- d. Doff gloves and perform hand hygiene.

- v. Apply eye protection
- vi. Apply hair cover
- vii. Apply shoe covers (if preferred)
- viii. Apply clean non-sterile gloves
- b. Enter the intermediate area the carpet side after leaving COVID_19 exposure area:
 - i. Remove gloves and gown
 - ii. Perform hand hygiene
 - iii. Don clean gloves
 - iv. Remove hair cover
 - v. Remove eye protection, disinfect with wipes
 - vi. Remove N-95 rebreather, follow disinfection procedure (see attached)
 - vii. Remove shoe covers (if worn)
 - viii. Doff gloves
 - ix. Perform hand hygiene

D. ALL residents throughout the facility will be monitored three times daily by medication nurse during a confirmed or suspected COVID-19 case. (see attached for documentation specifics)

- i. All residents will be monitored for full set of vitals including pulse ox three times daily through the MAR.
- ii. All residents will have a completed INFECTION SCREENING ASSESSMENT twice daily in the assessment tab in PCC.

E. Procedure for infection screening residents with a suspected or confirmed case of COVID-19 at ISCH-P.

- a. Vitals including pulse ox, this is located in the MAR and will be done, initially, every three hours.
- b. All residents will have an Infection Assessment at least **TID daily**.
- c. Additional vitals monitoring and nursing assessments may be needed for those with suspected or confirmed COVID-19 as their condition can change rapidly.

F. Caring for Residents with suspected COVID-19

Caring for residents with asymptomatic or mild COVID-19 is similar to caring for resident with other respiratory infections, **but COVID-19 can very quickly develop into a moderate/severe disease.**

- a. Mild COVID-19
 - i. Door to resident room to remain closed, at all times.
 - ii. Encourage resident to wear either an oxygen mask for delivery or surgical mask at all times to decrease the COVID-19 viral load in the room.
 - iii. Residents will require frequent monitoring of vitals and lung sounds
 - iv. Encourage fluid and food intake.
 - v. Encourage residents with increased oxygen needs to sit up to allow full lung expansion.
 - vi. Provide additional oxygen support when needed.
- b. Moderate/Severe COVID-19

Some of the possible complication of COVID-19 currently include but are not limited to are: Pneumonia, Sepsis, ARDS, Stroke and Embolisms. There will be additional monitoring of COVID-19 positive or suspected residents that will need to be done at least once per shift but may need

more frequent as the residents' condition progresses. The monitoring will be documented in a shift nurse note.

- i. Modified Early Warning Score (MEWs) must be complete at least once a shift to monitor possible development of SIRs/Sepsis. (see attached)
- ii. Vitals and lung sounds will be monitored for possible development of pneumonia
- iii. Monitoring for signs and symptoms of stroke such as changes in mentation, facial drooping, sided weakness, change in speech.
- iv. Monitor for signs and symptoms of embolism such as skin temperatures for extremities, discolorations and changes in sensation in hands and feet.

G. Procedure for Residents with diagnosed or suspected COVID-19 needing transport to PMC, they require a higher level of care than we can provide.

COVID-19 residents needing a higher level of care include but are not limited to: changes in MEWs scores, elevated temperature, elevated respiration rate, chest pain/pressure, acute or new onset confusion, difficulty to rouse, bluish lips/face, difficulty breathing, signs or symptoms of stroke or embolisms.

- a. Contact PMC and ambulance transport provider indicate resident is suspected or positive COVID-19 and needs transport to via ambulance.
- b. Contact Provider, Administrator, DNS, IP nurse.
- c. Follow discharge procedure.
- d. Resident will be maintained in a private room with the door closed while waiting transport to the hospital via urgent/ambulance transport.
- e. If resident is not wearing an oxygen face mask, they will be provided a surgical mask to limit COVID-19 exposure to transferring HCP.

H. Procedure for Discontinuing COVID-19 positive residents from modified airborne precautions.

- a. Test-based strategy
 - i. Resolution of fever without the use of fever-reducing medications AND
 - ii. Two negative COVID-19 test collected >24 hours apart.
- b. Non-test-based strategy
 - i. At least >72 hours asymptomatic without medications to mask or eliminate signs or symptoms AND
 - ii. At least 7 days have passed since symptoms first appeared.
- c. Resident who are discontinued must be assisted with a shower and clothing change prior to returning to their room.
- d. Residents who are discontinued from the modified airborne precautions will be encouraged to stay in their room and wear cloth face mask for 14 days after the first symptoms appeared.

Developed/Revised 3/4/2020-4/20/2020

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)

- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 persons under Investigations) Among Residents and Staff in Nursing Homes*. REF. QSO-20-25-NH
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- d. Centers for Disease Control and Prevention, Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- e. Centers for Disease Control and Prevention, *Coronavirus Disease 2019* <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- f. Centers for Disease Control and Prevention, *COVID-19 Symptoms of Coronavirus*. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>
- g. United States Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*. (Updated April 16, 2020). <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>

RESPIRATORY INFECTION PROCEDURE

Purpose:

Respiratory infection procedure is created to establish procedures for controlling exposure to respiratory infections of unknown pathogen to limit outbreaks in the Home.

- 23. Place all residents with respiratory symptoms in a private room with a private bathroom or bedside commode if possible, if no private room is available cohort resident with a resident with like symptoms.
- 24. Enter an order for droplet precautions, unless specified pathogen indicates otherwise, follow transmission precaution procedure for appropriate precaution.

Droplet Precautions shall be used in addition to Standard Precautions for residents with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the residents coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning.

Resident Placement:

- 3. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement, with a private or unshared bathroom.

Personal Protective Equipment (PPE)

- 11. Hand hygiene should be performed prior to applying PPE.
- 12. Gown, gloves and surgical face mask should be worn when entering the room and while providing care for a resident.
- 13. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
- 14. Gloves, gown and surgical face mask should be removed before leaving the resident's room and hand hygiene should be performed immediately.

15. After glove removal and hand washing, hands should not touch potentially contaminated environmental surfaces or items.

Transport

Movement and transportation of the resident will be limited. If transport is necessary, contact receiving provider to inform about precautions utilized as well as infecting pathogen. Resident should be provided mask to minimize dispersal of droplets.

Equipment for resident with infection and/or a contagious disease

7. Dedicated resident-care equipment should be considered for the resident and left in the room for the duration of the precautions.
8. Resident paper service meals provided in resident room for the duration of the precautions.
9. If use of common equipment or items is unavoidable, the items should be adequately cleaned and disinfected using EPA approved, pathogen specific, products following the manufacturing instructions before use for another resident.

Regulated Waste during Transmission Precautions pertinent to this procedure is defined as:

- a. Liquid or Semi-liquid blood or other potentially infectious materials (OPIM).
 - b. Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed.
 - c. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling.
11. In the case of Regulated Waste and Contaminated Healthcare Linen:
 - a. Regulated Trash will be placed in red biohazard trash bags and placed in the appropriate container in resident's room. Red bagged trash is removed from the room when full and as needed by nursing staff. Place red biohazard bags from the resident's room in the large red resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as biohazard container in the soiled utility room.
 - b. Contaminated Linen will be placed in red biohazard bags in the appropriate container in needed by placing the red bagged biohazard linen in the soiled linen cart in the soiled linen room.
 12. For residents on precautions dining in their room, disposable meal service should be utilized.
 25. Notify Provider, Administrator, DNS, Infection Prevention Nurse and family.
 26. When at least 3 patients are ill within 72 hours of each other Infection Prevention Nurse will notify Southeaster Health Department.
 27. Housekeeping to increase cleaning and disinfection of all high touch surfaces.
 28. Transport aide to clean/disinfect transport vehicle between each transport.

Revised 01/15, Revised 04/19, 4/20

References:

- e. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(e)(f)
- f. CDC, *Information for Health Professionals (Influenza)*. (Reviewed January 2, 2020). <https://www.cdc.gov/flu/professionals/index.htm>.
- g. CDC, *Interim Guidance for Influenza Outbreak and Management in Long Term Care and Post-Acute Care Facilities*. (Reviewed November 1, 2019). <https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>.

- h. CDC, *Influenza Antiviral Medications: A Summary for Clinicians*. (Reviewed January 15, 2020). <https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>.
- i. United States Environmental Protection Agency, *Selected EPA-Registered Disinfectants*. (Updated April 16,2020). <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>

PROCEDURE FOR STAFF AND CONTRACTORS REPORTING TO WORK

Purpose:

To provide optimal protection against community spread droplet and aerosolized pathogens from entering ISVH-P on clothing, footwear and respiratory expiration from possible asymptomatic staff and contractors.

1. Staff will report to the screening desk wearing a facility-maintained cloth mask from the previous day's work.
2. Staff and contractors will be asked a series of questions about their exposure risk factors such as but not limited to: close contact with someone with signs or symptoms of a respiratory infections, other workplace activities in the past 48 hours, exposure to a person with suspected or confirmed COVID-19, travel history, etc.
3. Staff and contractors will be asked a series of questions about possible symptoms associated with COVID-19 disease such as but not limited to cough, sore throat, malaise, loss of taste or smell, etc.
4. Staff and contractors will then have their temperature taken (using no touch thermometer).
5. If there is a temperature at or over 100.0, staff will immediately be sent home and all surfaces they have touched will be disinfected.
6. 48 hours look back on areas the staff and contractors have worked and the people they have worked in close contact with will be documented for close monitoring.
7. After successful screening, trained screening staff, will observe hand hygiene and disinfection of any equipment brought into the resident protected care area (cellphones, keys, drink containers, etc.).
8. Staff and contractors will then pick out new facility-maintained cloth mask from provided supplies.
9. Staff and contractors will remove previous days facility-maintained cloth mask and apply the new facility-maintained cloth face mask assuring it covers nose and mouth completely, securing both the top ties and bottom ties if applicable.
10. Previous days facility-maintained cloth mask will be placed in the appropriate dirty bin.
11. Staff and contractors will then pick out scrubs.
12. Remove all outside "street" clothing/shoes/slippers/ect. in dressing room and don clean scrubs, facility-maintained shoes.
13. Report directly to workstation behind the double doors (direct care side).
14. Staff and contractors will keep same scrubs on for your shift. Do not leave campus or sit in your vehicle (please feel free to walk outdoors but be mindful of who/what you come in contact with.) If leaving campus is unavoidable staff or contractors must change back into their street clothes and shoes and repeat steps 1-9 upon return to the facility.
15. Any soiled scrubs should be changed out immediately with this same process.
16. At the end of your shift, pass through the locker/changing room, dress in street clothes/shoes and place the used scrubs in the wash bin. All other items should be placed in your locker.

Developed 3/2020, Revised 4/2020, Revised 5/5/2020

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- c. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov//infectioncontrol/guidelines/isolation>
- d. Centers for Disease Control and Prevention, *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes* (April 15, 2020). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

5/2020

Pocatello Home Entry Screening Sheet:

Employee/Contractor Name: _____ Work Unit: _____ Position: _____

1. If dual employed, what other facilities or companies have you worked at in past 48 Hours?
2. Have you or any household members been, or are currently being, tested for COVID outside of SVH?
3. Are you exhibiting, or have exhibited, any of the following respiratory symptoms within the past 72 hours?
 - a. Sore throat
 - b. Cough
 - c. Shortness of breath
 - d. Loss of taste or smell
 - e. Chills/shaking
 - f. Muscle Pain
 - g. Headache
4. In the last 14 days, have you had close contact with anyone who is currently sick with respiratory illness or fever or anyone with a confirmed case of COVID-19? "Close Contact" is defined as contact with a person suspected of or confirmed with COVID-19 at less than 6-foot distance for at least 10 minutes without PPE.
5. Take and record temperature

If employee/contractor responds 'Yes' to questions 2, 3,4, or 5 above, **STOP** screening process **and contact 2nd Screener:**

- A. Monday through Friday, notify DNS (208-680-2099) or IP RN (208-643-2740)
- B. Weekends or after hours, notify Charge RN (208-235-7846)
- C. Notify Home Administrator by text only (208-241-8638)

If employee/contractor has a temperature of 100.0 degrees or greater send home and have them contact HR.

Note: After taking temperature, write: date, time, and screener's initials on approved screening tags provided. Have employee/contractor place on left front shoulder area.

If employee/contractor does not have a fever or signs of respiratory illness, proceed with having them use hand sanitizer and remind them to wash their hands or use ABHR throughout their time in the building. Also remind them to not shake hands with, touch, or hug individuals during their visit.

Date	1. Other location(s)	2. You or Household Member Tested for COVID-19	3a. Sore Throat	3b. Cough	3c. Shortness of Breath	3d. Loss of taste	3e. Chills/shaking	3f. New unexplained	3g. Headache	4. Close contact w/	5. Temp	Screener's Initials	Referred to 2 nd Screener	If Referred, Contact (Name)
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	worked w/in 48 hours	Outside of SVH				e or smell	g with chills	muscle pain		person				
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
Date	1. Other location(s) worked w/in 48 hours	2. You or Household Member Tested for COVID-19	3a. Sore Throat	3b. Cough	3c. Shortness of Breath	3d. Loss of taste or smell	3e. Chills shaking with chills	3f. New unexplained muscle pain	3g. Headache	4. Close contact w/ person	6. Temp	Screeners' Initials	Referred to 2nd Screener	If Referred, Contact (Name)
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
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		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	
		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N	

VISITOR PROCEDURE

Purpose:

To support family connection and relationships while providing optimal protection to residents, staff, contractors and families.

1. Visitors will call the Home to arrange the visitation time to assure designated visiting area is able to maintain physical distancing.
2. Instructions to wear cloth face covering and limit the number of visitors will be provided to visitors at the time of the call.
3. If cloth face covering is not in place on arrival, staff will provide face covering during screening and for the duration of the visit.
4. Visitor to get screened for symptoms (including temperature) and possible risk factors.
 - a. Screener to follow screening algorithm to assess if the visit can occur or will need to be rescheduled.
5. Visitors passing the screener will then receive brief instructions about keeping COVID-19 out of the home as well as the visitor handout.
 - a. Hand hygiene observed performance
 - b. Cough etiquette
 - c. Donning of PPE observed (gloves and gown)
 - d. Instruction given to contact Infection Prevention Nurse or designee if they develop signs or symptoms of COVID-19 within 14 days after their visit.
 - e. Encourage visitors to practice physical distancing of at least 6 feet during visit.
 - f. Remain in the designated visitors area, if you need to leave the designated visitor area please alert staff.
6. Resident will then meet the visitor in the designated visitors area.
7. At visitation completion staff will instruct visitor on PPE removal.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
 - b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
 - c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Nursing Home Reopening Recommendations for State and Local Officials (May 18, 2020)*. REF. QSO-20-30-NH
 - d. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
 - e. Centers for Disease Control and Prevention. *Preparing for COVID-19 in Nursing Homes (May 19, 2020)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- Developed 5/27/2020

VISITOR EDUCATION HANDOUT

Thank you, in advance, for assisting us in keeping our Veterans safe COVID-19.

Face Coverings

- A. Should be worn at all time while in the Home over both nose and mouth
- B. They are a physical barrier to inhibit the spread of COVID-19 in asymptomatic and presymptomatic people.
- C. Face coverings are not a substitute for physical distancing

Physical distancing

- A. Please maintain a 6 foot distance with residents and staff to inhibit the spread of COVID-19.

Hand hygiene

- A. Handwashing Steps:
 - a. Wet your hands
 - b. Lather the palms and backs of your hands, between fingers and thumbs and under nails.
 - c. Scrub hands for at least 20 seconds.
 - d. Rinse hands from wrists down
 - e. Dry your hands (bacteria/yeast/viruses LOVE moisture!!!)
- B. Hand Sanitizer Steps:
 - a. Apply the product
 - b. Rub your hands together
 - c. Cover the gel on all surfaces until your hands are dry (this should take about 20 seconds).

Cough etiquette:

- d. Cough or sneeze into a tissue
- e. Immediately throw tissue in trash
- f. Practice hand hygiene
- g. If tissue is not immediately available cough or sneeze into your elbow
- C. Limit physical touching of our residents, staff and environment.
- D. Stay in the designated visitors area, if you need to leave the designated visitor area please alert staff.
- E. Limit your visit to your loved one.
- F. If you develop symptoms of COVID-19 within 14 days of your visit please contact the Infection Prevent Nurse 208-235-7843.
 - a. Cough
 - b. Fever or chills

- c. Shortness of breath/difficulty breathing
- d. Fatigue
- e. Muscle/Body aches
- f. Headache
- g. Sore throat
- h. Congestion or runny nose
- i. Nausea/vomiting
- j. Diarrhea
- k. New Loss of taste or smell.

Thanks again, for your patients and assistance in helping us to keep our Veterans safe during this ever evolving pandemic.

Visitor Name: _____ Resident _____ Phone number: _____ Email: (if available) _____

Screener Instructions:

- Visitors must be screened upon entry to the facility.
- The screener must complete the questionnaire for the visitor. Place a 'Yes' or 'No' in each field indicating the visitor's response
- A completed screening must be on record for every date the visitor enters the facility.
- Visitors that enter the facility are required to perform hand hygiene and use Personal Protective Equipment (PPE), as appropriate.
- Visitors must restrict their visit to the resident's room or designated visiting area. They should also be reminded to frequently perform hand hygiene.
- Visitors with symptoms of a respiratory infection (fever, cough, shortness of breath, sore throat, loss of taste or smell, chills/shaking, muscle pain, headache) **should not be permitted** to enter the facility.
- Any yes answer of the below screening questions (except for PPE), STOP screening process, and contact 2nd Screener:
 - Monday through Friday, notify DNS (208-680-2099) or IP RN (208-643-2740)
 - Weekends or after hours, notify Charge RN (208-235-7846)
 - Notify Home Administrator by text only (208-241-8638)

Note: After taking temperature, write date, time, and screener's initials on approved screening tags provided. Have visitor place on left front shoulder area of PPE gown. Instruct visitors if they are diagnosed with COVID-19 or placed on quarantine within 14 days of visiting the facility they are to notify the facility.

Date	Since your last visit do you have new fever (100.0 or greater)	Since your last visit do you have a new cough that is not attributable to another condition?	Since your last visit do you have new shortness of breath that is not attributable to another condition?	Since your last visit do you have a new sore throat that is not attributable to another condition?	Since your last visit do you have new muscle aches that is not attributable to another condition or specific activity (physical exercise)?	Since your last visit do you have loss of taste or smell that is not attributable to another condition?	Since your last visit do you have chills/shaking that is not attributable to another condition?	Since your last visit do you have a headache that is not attributable to another condition?	PPE instructions provided/ Visitor demonstrated proper application of PPE	Temp	Screener's initials
	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N		
	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N		
	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N		

STAFF TESTING PROCEDURE

COVID-19 Staff Testing Procedure

Purpose:

To actively detect asymptomatic or presymptomatic transmission within the Home.

If you are coming from home

1. please do not enter the building
2. don your face mask
3. go to the designated testing site
4. after your test you are free to go.

If you are leaving your shift

1. please change into your street clothes
2. leave from the dock doors
3. go to the designated testing site
4. after your test you are free to go home.

If you are doing the test and need to finish your shift

1. change into street shoes
2. exit the dock doors
3. go to the designated testing site
4. after your test return to the loading dock door
5. perform hand hygiene
6. change into clean scrubs and face mask
7. finish your shift.

Physical distancing must be maintained while waiting for testing.

References:

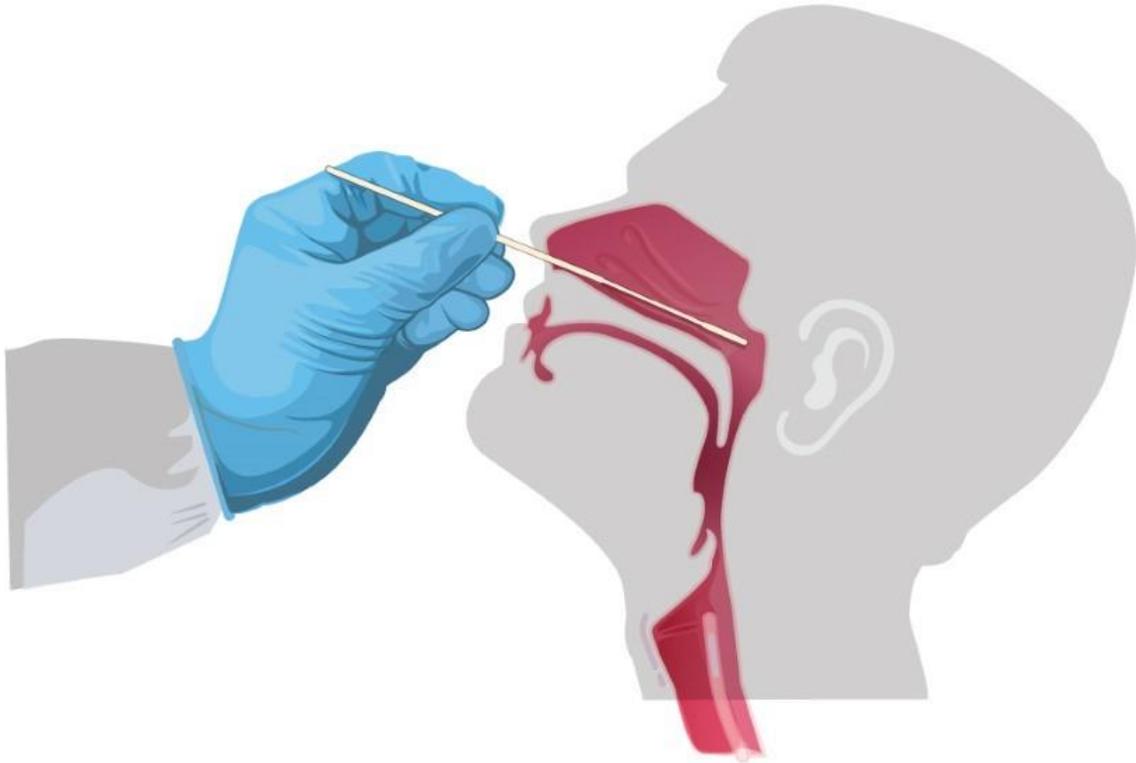
- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Nursing Home Reopening Recommendations for State and Local Officials (May 18, 2020)*. REF. QSO-20-30-NH
- d. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- e. Centers for Disease Control and Prevention. *Preparing for COVID-19 in Nursing Homes (May 19, 2020)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

Developed 5/27/2020

SPECIMEN COLLECTION

COVID-19 Specimen collection

I. Respiratory Specimens A. Upper respiratory tract Nasopharyngeal (NP) swab/oropharyngeal (OP) swab



COVID-19 NP Swab: The Wrong Way



Use only synthetic fiber swabs with plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing. Place swabs immediately into sterile tubes containing 2-3 mL of viral transport media. In general CDC is now recommending collecting only the NP swab. If both swabs are used, NP and OP specimens should be combined at collection into a single vial. OP swabs remain an acceptable specimen type.

Improper technique has resulted in a 30% false negative rate so it is imperative to perform this test correctly. We will assign only a few nurses who will do the collection to limit standard deviations.

Nasopharyngeal swab: Insert flexible wire shaft minitip swab through the nares parallel to the palate (not upwards) until resistance is encountered or the distance is equivalent to that from the ear to the nostril of the patient, indicating contact with the nasopharynx. Swab should reach depth equal to distance from nostrils to

outer opening of the ear. Gently rub and roll the swab. Leave swab in place for several seconds to absorb secretions. Slowly remove swab while rotating it.

II. Storage

Store specimens at 2-8°C for up to 72 hours after collection. If a delay in testing or shipping is expected, store specimens at -70°C or below.

III. Shipping

Specimens must be packaged, shipped, and transported according to the current edition of the [International Air Transport Association \(IATA\) Dangerous Goods Regulations external icon](#).

If shipping samples to CDC: If specimens will ship without delay, store specimens at 2-8°C, and ship overnight to CDC on ice pack. If a delay in shipping will result in receipt at CDC more than 72 hours after collection, store specimens at -70°C or below and ship overnight to CDC on dry ice. Additional useful and detailed information on packing, shipping, and transporting specimens can be found at [Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 \(COVID-19\)](#). Samples may be shipped to CDC if repeated testing results remain inconclusive or if other unusual results are obtained. Please contact CDC at respvirus@cdc.gov prior to submitting samples.

Label each specimen container with the patient's ID number (e.g., medical record number), unique CDC or state-generated nCov specimen ID (e.g., laboratory requisition number), specimen type (e.g., serum) and the date the sample was collected.

<https://www.bing.com/videos/search?q=how+to+collect+covid-19+nasopharyngeal+swab&ru=%2fvideos%2fsearch%3fq%3dhow%2bto%2bcollect%2bcovid-19%2bnasopharyngeal%2bswab%26qs%3dn%26form%3dQBVR%26sp%3d-1%26pg%3dcovid-19%2bnasopharyngeal%2bswab%26sc%3d8-28%26sk%3d%26cvd%3d8C9F2F1581E54F169541707AFA894398&view=detail&mid=9EBE4353FA1FA070205E9EBE4353FA1FA070205E&&FORM=VDRVRV>

Developed 4/28/2020

References:

- a. Centers for Disease Control and Prevention, *Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (Covid-19)* (Updated April 14, 2020). <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>
- b. Centers for Disease Control and Prevention, *Influenza Specimen Collection*. <https://www.cdc.gov/flu/pdf/professionals/flu-specimen-collection-poster.pdf>

REPORTING POSITIVE COVID-19 CASES

Purpose:

To provide direction for rapid delivery of COVID-19 positive results to the appropriate authorities and assure minimal infectious exposure to residents, staff and contractors.

DNS or designee will receive results from the testing laboratory with positive results.

1. For COVID-19 positive staff or contractor who is in the facility DNS or designee:
 - a. Will immediately and discreetly excuse them from their duties
 - b. Inform staff member of their positive status
2. DNS will then activate the IDVS COVID-19 Crisis Communications Plan.
3. All residents, staff, contractors and family members will be notified of a COVID-19 case in the facility, before 5pm the next day.
4. For COVID-19 positive staff or contractor not in the facility, DNS or designee will notify IP nurse or designee
5. DNS will then activate the IDVS COVID-19 Crisis Communications Plan

6. All residents, staff, contractors and family members will be notified of a COVID-19 case in the facility before 5pm the next day.
7. IP nurse or designee will:
 - a. Call them informing them of their positive status
 - b. Conduct a 7-day history investigation of all the residents, staff and contractors contacts to see if they have had close contact (within 6 feet for more than 10 minutes).
 - c. Complete a risk assessment for staff using the CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Health Care Setting to Patients with COVID-19.
 - d. Place all residents who were in close contact with the COVID-19 positive person in the COVID-19 ward until their COVID-19 status is negative and can be moved back to their room.
 - e. Call Regional Health Department to up the investigation findings and list of persons under investigation (PUIs)
8. For COVID-19 positive resident, DNS or designee will immediately isolate resident, closing door to shared bathroom and hallway door, while preparations for move to COVID-19 wing are made.
9. DNS will activate the IDVS Coivid-19 Crisis Communication plan.
10. All residents, staff, contractors and family members will be notified of a COVID-19 case in the facility, before 5pm the next day.
11. IP nurse or designee will initiate the investigation process:
 - a. Conduct a 7-day history investigation of all the residents, staff and contractors contacts to see if they have had close contact (within 6 feet for more than 10 minutes).
 - b. Complete a risk assessment for staff using the CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Health Care Setting to Patients with COVID-19.
 - c. Place all residents that were in close contact with the COVID-19 positive person in the COVID-19 ward (not in the same room with the positive case) until their COVID-19 status is negative and they can be moved back to their room.
 - d. Call Regional Health Department to notify of the investigation findings and list of persons under investigation (PUI)

Developed 5/15/2020

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 persons under Investigations) Among Residents and Staff in Nursing Homes*. REF. QSO-20-25-NH
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- d. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff In Nursing Homes*. F884, F885. REF. QSO-20-29-NH
- e. Centers for Disease Control and Prevention, Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for*

Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings <http://www.cdc.gov/infectioncontrol/guidelines/isolation>

f. Centers for Disease Control and Prevention, *Coronavirus Disease 2019* <https://www.cdc.gov/coronavirus/2019-ncov/index.html>

g. Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Health care Setting to Patients with COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

h. Centers for Disease Control and Prevention, *Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Setting (Interim Guidance)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 <i>(until 14 days after last potential exposure)</i>
Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) wearing a cloth face covering or facemask (i.e., source control)		
HCP PPE: None	Medium	Active
HCP PPE: Not wearing a facemask or respirator	Medium	Active
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision
HCP PPE: Not wearing gown or gloves ³	Low	Self with delegated supervision
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision
Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) not wearing a cloth face covering or facemask (i.e., no source control)		
HCP PPE: None	High	Active
HCP PPE: Not wearing a facemask or respirator	High	Active

HCP PPE: Not wearing eye protection ^b	Medium	Active
HCP PPE: Not wearing gown or gloves ^{a,b}	Low	Self with delegated supervision
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator) ^b	Low	Self with delegated supervision



Communication Plan
 COVID-19 Suspected, Positive Diagnosis and Resident Death
 Last Updated: 05/14/20

Event

COVID-19 suspected, positive diagnosis, or caused death of resident or staff at an Idaho State Veterans Home. Also, residents with severe respiratory infections resulting in hospitalization or death, or 3 or more residents or staff with new onset of respiratory symptoms within 72 hours if each other.

Use

Upon the diagnosis or death of a resident or staff member at an Idaho State Veterans Home. Upon residents with severe respiratory infections resulting in hospitalization or death, or 3 or more residents or staff with new onset of respiratory symptoms within 72 hours of each other. In addition to regulatory mandates, conform to these strict communication plans to ensure aligned communication with State authorities. See CMS QSO-20-29-NH for specific facility reporting requirements.

Crisis Communications Response Team

NAME	TITLE	CELL PHONE	OFFICE LINE	EMAIL
Marv Hagedorn	Chief Administrator	(208) 867-5643	(208) 780-1304	marv.hagedorn@veterans.idaho.gov
Tracy Schaner	Deputy Chief Administrator	(208) 473-1597	(208) 780-1320	tracy.schaner@veterans.idaho.gov
Rick Holloway	ISVH Administrator - Boise	(208) 412-9140	(208) 780-1610	rick.holloway@veterans.idaho.gov
Mark High	ISVH Administrator - Lewiston	(208) 406-6248	(208) 750-3610	mark.high@veterans.idaho.gov
Josiah Dahlstrom	ISVH Administrator - Pocatello	(208) 241-8638	(208) 235-7810	joslah.dahlstrom@veterans.idaho.gov
Paul Spannkebel	Bureau Chief —Business Support Services	(208) 559-7988	(208) 780-1322	paul.sjaannkebel@veterans.idaho.gov
Colleen Moon	Quality Imp. Dir. / Boise Asst. NHA	(208) 604-3854	(208) 780-1614	colleen.moon@veterans.idaho.gov

Media Point of Contact

ORGANIZATION	Name	TITLE	PRIMARY PHONE	EMAIL
IDVS	Paul Spannkebel	Business Sup. Bureau Chief	(208) 780-1322	paul.spannknebel@veterans.idaho.gov
IDVS	Marv Hagedorn	Chief Administrator	(208) 780-1304	marv.hagedorn@veterans.idaho.gov
IDVS	Tracy Schaner	Deputy Chief Administrator	(208) 780-1320	tracy.schaner@veterans.idaho.gov
IDVS	Kevin Walllor	Management Asslstant	(209) 780-1308	kevin.walllor@veterans.idaho.gov

Stakeholders Contact Information

ORGANIZATION	Name	TITLE	PRIMARY PHONE	EMAIL
Governor's Communication Office	Emily Callihan	Communications Director	0: (208) 854-3032 M: (208) 559-3920	emily.callihan@gov.idaho.gov
Governor's Office	Louis Hougaard	Policy Advisor/IDVS Liaison	0: (208) 854-3023 M: (801) 879-3981	louis.hougaard@Nov.Idaho.gov
IDHW	Debby Ransom	Chief Bureau of Facility Standards	(208) 334-6626, option 5	debby.ransom@dhw.idaho.gov
CDC National Healthcare Safety Network	NA	NA	NA	https://www.cdc.gov/nhsn/
Office of Geriatrics & Extended Care	Lisa Mlnor	Director, Facility Based Programs	email	Lisa.mlnor3@va.Nov
Office of Geriatrics & Extended Care	Valarie Delanko	SVH Quality & Oversight Program Manager	email	valarie.delanko@va.gov
Office of Geriatrics & Extended Care	Jo Anne Parker	SVH Survey Program Manager	email	joanne.parker3@va.gov
NASVH	Mark Bowman	President	email	mark.bowman@ky.gov
IVAC	Josh Callhan	Commissioner	(208) 841-2431	joshua.callihan@va.gov
IVAC	Art Gimpel	Commissioner	(208) 521-4787	arthurgimpel@outlook.com
IVAC	Patrick Grace	Commissioner	(208) 407-2595	patrick.grace@dbs.idaho.Nov
IVAC	Jinny Cash	Commissioner	(208) 983-1033	ldcovets@gmail.com
IVAC	Leo Dub	Commissioner	(208) 669-0471	Via Telephone
Idaho Commission on Aging	Amanda Scott	State LTC Ombudsman	(208) 577-2855	amanda.scott@aglng.idaho.gov

Enclosure A
COVID-19 INCIDENT RESPONSE ACTION PLAN
 CHART

Trigger or Time	Action	Responsibility
COVID-19 confirmed diagnosis or death	1. Receive test results/notification of death	
Immediately Upon Notification	2. Inform Deputy Chief at CSO and provide details in resident spread sheet. (Resident Spread Sheet at Encl # B)	Home Administrator
Immediately Upon Notification	3. Inform Gov's Office	Chief Administrator, Deputy Chief Administrator
Immediately Upon Notification	4. Inform Health District	Infection Control Preventionist
Immediately Upon Notification	5. Inform resident & their representative/family	DNS, RN Manager, Infection Control Preventionist
As Soon as Practical — per CMS must be by 5 p.m. next calendar day & prior to any <u>Media or Press Release</u>	6. Communicate with residents, and all other representatives & families for all residents who do not have a positive case. (Family Communication SOP at Encl C & Family Call Script at Encl D)	Social Workers, Designated Staff
As Soon as Practical - per CMS must be by 5 p.m. next calendar day & prior to any <u>Media or Press Release</u>	7. Communicate via email or video message with all IDVS employees following discussion and guidance from Business Sup. Bureau Chief In addition, the Home Administrator will brief oncoming shifts at the home.	Chief Administrator or Deputy Chief Administrator, and Home Administrators
As Soon as Practical- within 12 hours (CDC NHSN — 1x/per week)	8. Inform IDHW/BFS and enter in CDC NHSN system. Also inform VAMC leadership and copy OGEC, NASVH President and Deputy Chief Administrator.	Home Administrator
As Soon as Practical	9. Communicate to City Leaders, Legislators, Congressional delegation	Chief Administrator
As Soon as Can be Arranged	10. In cases of death: conduct honor ceremony	Home Administrator, Chaplin
11:00AM Daily M-F	11. Continue to conduct daily COVID-19 Prevention Call with Deputy Chief Administrator, Home Administrators, Quality Imp. Dir/ Asst., DNSs, and Infection Control Preventionists	Deputy Chief Administrator
3:00PM Daily M-F	12. Prepare a daily update for the Office of the Governor and other essential persons. Discuss with Chief Administrator by 4:00PM to send to the Office of the Governor by 5:00PM (Encl F).	Deputy Chief Administrator
4:00PM Daily M-F	13. Conduct a teleconference between Chief Administrator, Deputy Chief Administrator, Home Administrator and Business Sup. Bureau Chief at 4:00PM upon any new cases being identified.	Chief Administrator, Deputy Chief Administrator
5:00 PM Daily	14. Update COVID-19 Message Hotline by 5 PM daily (Encl E).	Business Sup. Bureau Chief

Enclosure C
RESIDENT REPRESENTATIVE/FAMILY COMMUNICATION
SOP

Family Communication SOP as of 04/13/2020 (Revised 5/12/20)

In dealing with COVID-19 in our Homes, there are two critical communication points where we need to be able to inform the families of unaffected residents in a timely manner: 1) After a positive test result and 2) upon the death of a resident.

To accomplish this, below is an SOP to coordinate roles and responsibilities:

<p>Family Letters</p>	<ol style="list-style-type: none"> 1. Management Assistant works with the Deputy Chief Administrator, and Home Administrator to ensure all drafted letters are using technically correct phrases. This is a priority ask. We will need to develop this communication quickly. 2. Drafts need to be approved by the Deputy Chief Administrator. 3. Home Administrative Assistants and/or Business Office staff will print and send letter to family via one- day mail. Management Assistant will post on Website 	<p>Management Assistant, Deputy Chief Administrator, Home Administrator</p> <p>Deputy Chief Administrator</p> <p>Home Admin. Assistants, B.O., Management Assistant</p>
<p>Phone calls to all families (completed within 2-3 hours following event, if at all possible due to potential media release and no later than 5 p.m. next calendar day per CMS)</p>	<ol style="list-style-type: none"> 1. Home Administrator works with Social Service staff and/or designated staff members as the identified callers; prepare and assign call down lists. This list should be owned by the assigned caller for the duration of the event. 2. Use phone script talking points based on planned media and other important information. 3. Notify residents and complete calls to all representatives/families of residents no less than 3 hours after confirmed COVID19 diagnosis or the death of a resident, if at all possible, due to the COVID19 virus (sensitive timeline due to media releases). MUST be completed no later than 5 p.m. next calendar day per CMS 	<p>Home Administrator, Social Services, Designated Staff Callers</p> <p>Social Services, Designated Staff Callers</p> <p>Social Services, Designated Staff Callers</p>

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP guidance to surveyors for Long Term Care Facilities*. (November 2017 Revision) F880-Infection Prevention and Control. 42 C.F.R. 483.80(a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 persons under investigations) Among Residents and Staff in Nursing Homes*. REF. QSO-02-25-NH
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-29-NH
- d. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes* F884, F885. REF> QSO-20-29-NH
- e. Centers for Disease Control and Prevention, standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- f. Centers for Disease Control and Prevention, *Coronavirus Disease 2019*
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- g. Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Health Care setting to patients with COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>
- h. Centers for Disease Control and Prevention, *Discontinuation of Transmission-based Precautions and Disposition of Patients with COVID-19 in Healthcare Setting (Interim Guidance)*
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

Developed 5/15/2020

COVID-19 VISITOR PROCEDURE

Purpose:

To support family connection and relationships while providing optimal protection to residents, staff, contractors and families.

1. Visitors will call the Home to arrange the visitation time to assure designated visiting area is able to maintain physical distancing.
2. Instructions to wear cloth face covering and limit the number of visitors will be provided to visitors at the time of the call.
3. If cloth face covering is not in place on arrival, staff will provide face covering during screening and for the duration of the visit.
4. Visitor to get screened for symptoms (including temperature) and possible risk factors.
 - a. Screener to follow screening algorithm to assess if the visit can occur or will need to be rescheduled.

5. Visitors passing the screener will then receive brief instructions about keeping COVID-19 out of the home as well as the visitor handout (see attached).
 - a. Hand hygiene observed performance
 - b. Cough etiquette
 - c. Donning of PPE observed (gloves and gown)
 - d. Contact Infection Prevention Nurse or designee if they develop signs or symptoms of COVID-19 within 14 days after their visit.
 - e. Encourage visitors to practice physical distancing of at least 6 feet during visit.
 - f. Remain in the designated visitors area, if you need to leave the designated visitor area please alert staff.
6. Resident will then meet the visitor in the designated visitors area.
7. At visitation completion staff will instruct visitor on PPE removal.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- c. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Nursing Home Reopening Recommendations for Stat and Local Officials (May 18,2020)*. REF. QSO-20-30-NH
- d. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- e. Centers for Disease Control and Prevention. *Preparing for COVID-19 in Nursing Homes (May 19, 2020)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
Developed 5/27/2020

DURABLE GOODS ETC. QUARANTINE

Purpose:

To provide direction for disinfection and viral load reduction on all items brought into the Home providing optimal COVID-19 infection prevention.

- All items brought into the Home either by family for residents or brought to the Home for operations will be held in quarantine for a minimum of 48 hours.
- After 48 hours hard surface items such as plastic and metal will be disinfected using EPA approved COVID-19 specific disinfectants and follow the product instruction.
- After 48 hours all fabric items will be laundered by the facility using infection prevention CDC guidelines for both water temperature, detergents and drying protocol.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880-Infection Prevention and Control. 42 C.F.R. 483.80 (a)(2)(iii)

- b. Centers for Disease Control. *Background guidelines on Laundry and Bedding*.
<https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.htm>
- c. New England Journal of Medicine. *Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1*, (April 16, 2020).
<https://www.nejm.org/doi/full/10.1056/nejmc20004973>

Developed 3/16/2020, Revised 3/26/2020

COVID-19 PROCEDURE FOR RESIDENT NECESSARY APPOINTMENTS

Purpose:

To meet the resident's need for outside consultation, appointments while providing optimal safety for residents and staff during community spread of COVID-19.

1. Staff will review transportation/appointment schedule daily to assess necessity, rescheduling those that can be rescheduled and using Telehealth visits whenever possible.
2. When verifying appointments, transport aide or Ward Clerk will verify with the outside provider whether there is active COVID-19 in the area where the resident will be treated. If individuals with active COVID-19 could be in close proximity to the resident during the visit, further consideration should be made regarding the importance of the visit and the enhanced infection control measures which should be utilized to protect the resident.
3. Transport aide will provide a cloth face mask for residents prior to leaving for appointments and assist with donning cloth face mask if needed.
4. Transport aide will assist resident to remain >6 feet from people whenever possible.
5. Transport aide will assist with resident hand hygiene if resident touches other people or surroundings during appointment.
6. Transport aide will assist with resident hand hygiene prior to returning to the resident protected care area.
7. Transport aide will educate the resident about staying in room, wearing a cloth mask when out of room for 14 days and reporting to staff any signs or symptoms of respiratory illness such as coughing, rhinorrhea, sore throat, shortness of breath.
8. Staff will encourage all resident to remain in their rooms during COVID-19 community spread times.
9. Transport aide will report to charge nurse and IP nurse if there were people showing signs or symptoms of respiratory illness (coughing, sneezing, rhinorrhea) observed during the appointment.
10. Transport aide will disinfect high touch surfaces of the transport vehicle.
11. Resident will continue to be monitored at least daily using the Infection Assessment and a full set of vitals.

Developed 4/2020, Updated 5/29/2020

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Nursing Homes (REVISED)*. <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>
- c. Centers for Disease Control and Prevention, Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- d. Centers for Disease Control and Prevention, *Coronavirus Disease 2019, Use of Cloth Face Coverings to Help Slow the Spread of COVID-19* <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>
- e. Centers for Disease Control and Prevention, *COVID-19, People Who Need Extra Precautions, Older Adults* <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>

PROCESS FOR RESIDENT RETURNING FROM PASS

Purpose:

To provide optimal protection against community spread droplet and aerosolized pathogens from entering ISVH-P on clothing, footwear and respiratory expiration from residents that have been outside of the home on pass.

Upon return to the facility and before entering the resident care area:

1. The resident will be asked a series of questions about their exposure risk factors. These questions may include, but are not limited to close contact (less than 6 feet apart for more than 10 minutes) with someone with signs or symptoms of a respiratory infection, exposure to a person with suspected or confirmed COVID-19, travel history while on pass, close contact with a large group of people (>6-10 people), etc.
2. The resident will be asked a series of questions about possible symptoms associated with COVID-19 disease. These questions may include, but are not limited to new onset of cough, sore throat, malaise, loss of taste or smell, etc.
3. The resident will have his/her temperature taken with a no touch thermometer.
4. Any belongings brought into the facility with the resident will be placed in quarantine for the prescribed length of time, generally 48 hours.
5. The resident will be provided a clean facility issued mask.
6. Upon completion of successful screening, performing hand hygiene, and donning clean facility issued mask the resident may enter the resident care area.
7. The resident will be offered a shower and a change of clothes as soon as possible upon return.
8. The resident will be placed on a 14-day quarantine. This means the resident will be encouraged to remain in his/her room, but if they choose to come out of their room, they will be encouraged to wear a mask.

9. If the resident is positive for any of the risk factors or symptoms outlined above, they will be placed in a private room and the Infection Preventionist or designee will be contacted.
10. If there are any questions or concerns when the resident returns the Infection Preventionist or designee will be contacted.

Developed 5/2020

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- c. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov//infectioncontrol/guidelines/isolation>
- d. Centers for Disease Control and Prevention, *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes* (April 15, 2020). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

PROCEDURE FOR PERSONS DECLINING COVID-19 TESTING

Purpose:

To provide maximum Universal protection of ISVH-P while allowing self-determination and person-centered care.

Resident who decline COVID-19 testing.

1. For a current resident without risk factors (outside appointments/close physical contact with outside family/friends) declining COVID-19 testing:
 - a. Resident will be reproached and educated by staff to verify declination.
 - b. Resident declination of the COVID-19 test will be documented in EMAR.
 - c. Monitoring of vitals with infection assessment at least daily
 - d. Encourage resident to wear a cloth face covering or face mask when out of room
2. For a current resident with risk factors (outside appointments/close physical contact with outside family/friends) declining COVID-19 testing:
 - a. Resident will be reproached and educated by staff to verify declination.
 - b. Resident declination of the COVID-19 test will be documented in EMAR.
 - c. Monitoring of vitals with infection assessment at least daily
 - d. Encourage resident to remain in their room
 - e. If medically necessary to leave room, encourage resident to wear a cloth face covering or face mask when out of room for 14 days after the last risk (outside appointment or family/friend visit)
3. All newly admitted residents are educated about the COVID-19 testing procedure.
 - a. COVID-19 test will be administered approximately day 1, 7 and 14.
 - b. Resident will remain on quarantine (standard precautions unless they have signs or symptoms of respiratory infection)

- c. Considerations will be discussed with IDT if resident declines COVID-19 test procedures prior to admission.

References:

- e. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- f. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 persons under Investigations) Among Residents and Staff in Nursing Homes*. REF. QSO-20-25-NH
- g. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. REF. QSO-20-14-NH
- h. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff In Nursing Homes*. F884, F885. REF. QSO-20-29-NH
- i. Centers for Disease Control and Prevention, *Standard and transmission-based precautions to be followed to prevent spread of infections*, Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
<http://www.cdc.gov/infectioncontrol/guidelines/isolation>
- j. Centers for Disease Control and Prevention, *Coronavirus Disease 2019*
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- k. Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Health care Setting to Patients with COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- l. Centers for Disease Control and Prevention, *Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Setting (Interim Guidance)*.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
- m. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Nursing Home Reopening Recommendations for State and Local Officials (May 18, 2020)*. REF. QSO-20-30-NH

POSTMORTEM CARE IN PANDEMIC

Purpose:

To provide guidance for the preparation, transportation and temporary storage of resident remains, related to decreasing COVID-19, postmortem transmission.

In the event of a death of a resident the unit licensed nurse or his/her designee shall:

1. Immediately notify physician/provider for permission to release body/other instructions. (Document discussion in nurse progress notes.)
2. Immediately notify family and/or responsible party as delineated in face sheet of medical record. (Document discussion in nurse progress notes.)
 - a. Strongly encourage the family to view their relative once they've been transported to the funeral home. If family insists on seeing their family prior to the body transport to the funeral home, we will accommodate in the safest manner possible.
3. Notify mortuary identified in resident's record, alerting them of the resident COVID-19 status (negative/suspect/positive). (Funeral home instructed to meet staff at nearest outside exit to provide hand off of the gurney/body pouch for staff to prepare body and return to outside exit) (Document discussion in nurse progress notes.)
4. If the resident's death was UNEXPECTED immediately notify:
 - Director of Nursing Services
 - RN Manager
 - Social Services Director
 - Administrator
5. The Ward Clerk shall notify the above parties via e-mail notification (or shortly after arrival to work — if death did not occur during normal business hours).

POSTMORTEM CHARTING PROCEDURE

Include the following in your postmortem charting: (if resident is positive/suspected of COVID staff will wear full modified airborne PPE (gloves, gown, hair covers, N-95 masks and face shields/movement of the body can release infectious air from lungs postmortem)

1. Condition of patient when last seen alive (if applicable).
2. Condition of patient when found.
3. Checks made to determine death.
4. (i.e. Apical Pulse for 1 minute, respirations for 1 minute, blood pressure, corneal reflex, pupil size and reaction.)
5. Physical appearance.
 - Rationale for CPR if code status is not marked (i.e. color waxen, cyanotic, mottled, skin temperature, rigor status, restate pupil status).
 - If back-up nurse was called to confirm status, list those notified.
6. Complete mortician's receipt on back of face sheet.
 - Disposition of resident's belongings - valuables if pertinent, when body released, by whom, and to whom, signature to include name and title.
7. Fill out inventory sheet and valuables. Make sure personal belongings are boxed and sent to storage for safekeeping. Check locked drawers. Send all valuables to the Business Office.

NURSE AIDE POSTMORTEM CARE (if resident is positive/suspected of COVID staff will wear full modified airborne PPE (gloves, gown, hair covers, N-95 masks and face shields/movement of the body can release infectious air from lungs postmortem)

1. Report to licensed nurse by call system or in person.

2. Stay with nurse and resident.
3. Help with CPR if initiated.
4. If resident is determined to have died, move to private area.
2. Remove all tubes, IV, and foley as directed by nurse.
3. Wash body if soiled. Handle gently to prevent tissue trauma.
4. Place pad under resident.
5. Dress resident in gown open in the back.
6. Arrange in sleeping position.
7. Determine if teeth and glasses should be sent with the resident. If so, place on bed.
8. Cover with clean blanket or sheet as if asleep, do not cover face.
9. If family present (they will need to be screened and wear gowns, gloves and masks), allow for them to take personal items they would like and document what is taken and by whom. Close room and do not remove anything additional. Social Services and/or DNS will take care of personal items left in room.
10. Assist with mortician as requested to transfer body to gurney. (Funeral home staff are not to enter the facility)
11. Assign staff to wait by the designated outside exit to await the funeral home.
 - a. Staff appropriately disinfects the gurney and body pouch and brings it directly to the resident room.
 - b. Staff then prepares and moves the body to the gurney according to funeral home direction and move the body to the designated exit for transfer to the funeral home.
12. If other residents ask if someone has died, you may answer with a simple correct response such as “Yes, John has just died.” Give no other personal or medical details, remember the residents COVID-19 status is HIPPA protected information.

TEMPORARY POSTMORTUM STORAGE FOR MORTUARY OVERFLOW

1. Body will be prepared per protocol (if COVID-19 suspected or positive staff will wear gloves, gowns, N95 masks, and face shields).
2. Gather the body pouch or heavy plastic, place the remains in the pouch/plastic with documentation of name, date of birth, date of death, COVID-19 status and suspected cause of death. If multiple layers used, you must have the documentation described above in each layer.
3. Transport the remains covered with cloth to the nearest exit and bring outside to the back-loading dock to the temporary cold storage area.
4. Close the door of the resident room, leaving it undisturbed for at least 24 hours with disinfectant equipment, if COVID-19 suspected or positive.
5. Document the procedure in PCC.
13. After disinfection machine has completed the cycle or room has remained undisturbed staff only wearing full modified Airborne PPE can enter the room.
14. Nursing staff to remove and bag all personal items.
15. Housekeeping to clean from cleanest areas to dirtiest areas removing visible contaminant, then disinfect all surfaces.

References:

- a. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities*. (November 2017 Revision) F880 – Infection Prevention and Control. 42 C. F. R. 483.80 (a)(2)(iii)
- b. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. *Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Nursing Homes (REVISED)*. <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>
- c. Centers for Disease Control and Prevention, Standard and transmission-based precautions to be followed to prevent spread of infections and 483.80 (a)(2)(vi) Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the

Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* <http://www.cdc.gov/infectioncontrol/guidelines/isolation>

d. Centers for Disease Control and Prevention, *Collection and Submission of Postmortem Specimens from Deceased of Persons with Known or Suspected COVID-19* March 2020 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html>

e. Centers for Disease Control and Prevention, *Interim Infection Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 COVID-19 in Healthcare Settings* <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>