

**List of Laguna Honda Hospital and Rehabilitation Center (LHH)  
Hospital-wide/Department Policies and Procedures  
Submitted to the Joint Conference Committee (JCC) for Approval on  
June 23, 2020**

**Hospital-wide Policies and Procedures**

Revised Policies (page3)

<u>Policies</u>	<u>Comments</u>
72-01 A8 Outbreak/Epidemic Investigation Protocol	Revised to include procedures on how to identify and report when information becomes known that a resident(s) may be infected with a pathogen that is highly transmissible and/or virulent.
72-01 A9 Contact/Exposure Investigation	Revised to include procedures for evaluating and managing exposures or potential exposures of residents in the facility for the purpose of diagnosis, treatment, and isolation in order to prevent the transmission of the disease to others.
72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment	Revised to clarify procedures for cleaning and/or disinfecting multi-resident use equipment; added a procedure for consideration of equivalent products when standard hospital-wide approved disinfectants are unavailable; and added Attachment 1: LHH Non-Critical Resident Care Equipment Disinfectant Exceptions and Attachment 2: Standard Work for Single-resident Blood Pressure Cuffs.

**Department: Nursing Services**

Revised Policies (page 19)

<u>Policies</u>	<u>Comments</u>
C 3.2 Documentation of Resident Care by Nursing Assistant	Revised to reflect workflow for electronic health record (EHR); and added new attachment for ADL Coding.
C 9.0 Transcription and Processing of Orders	Revised to reflect workflow for EHR.
G 3.0 Intake and Output	Revised to reflect workflow for EHR.

**Department: Rehabilitation Services**

New Policies (page 35)

<u>Policies</u>	<u>Comments</u>
40-09 Treatment Authorization Request (TAR)	Created to ensure that therapists provide accurate and timely information for Medi-Cal TARs for submission to Medi-Cal.



# **Revised Hospital-wide Policies and Procedures**

## OUTBREAK/EPIDEMIC INVESTIGATION PROTOCOL

### POLICY:

Designated members of the Infection Control Committee (ICC) have the responsibility for investigating outbreaks/epidemics and developing policies aimed at ~~prevention~~ preventing the spread and control of healthcare-associated infections.

The threshold for determination of an outbreak is based on All Facilities Letter (AFL) 19-18, LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions, and outbreak definitions established by the ICC. Two or more of a similar infection in a period of 72 hours occurring on one neighborhood shall trigger an investigation of a possible outbreak.

### DEFINITIONS:

California Department of Public Health (CDPH) defines an outbreak as the occurrence of cases of a disease (illness) above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group. The number of cases indicating the presence of an outbreak will vary according to the disease agent, size and type of population exposed, previous exposure to the agent, and the time and place of occurrence.

Thus, the designation of an outbreak is relative to the usual frequency of the disease in the same facility or community, among the specified population, over a comparable period of time. For example, a single case of measles in this population may be considered an outbreak.

A single case of a communicable disease long absent from a population or the first invasion by a disease not previously recognized requires immediate reporting and epidemiologic investigation. The Infection Control Nurse (ICN) in conjunction with the ICC Chair will provide guidance when an outbreak /epidemic is occurring or suspected.

**Epidemic:** Centers for Disease Control and Prevention (CDC) defines an epidemic as an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. For example, 15 new cases of tuberculosis (TB) in the entire facility.

**Outbreak:** Outbreak carries the same definition of ~~epidemic, but epidemic but~~ is often used for a more limited geographic area. For example, 1 case of pertussis (whooping cough) on a neighborhood.

**Cluster:** Cluster refers to an aggregation of cases grouped in place and time that are suspected to be greater than the number expected, even though the expected number may not be known.

**Pandemic:** Pandemic refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.

**Transmissible:** ~~communicable~~ The ability of a disease/pathogen to be transmitted from one person or organism to another. Respiratory pathogens are more transmissible (more easily transmitted) than those transmitted by other means (mosquito bites, for example).

**Virulent:** ~~The Centers for Disease Control & Prevention (CDC)~~ defines virulence as the relative capacity of a pathogen to overcome body defenses; that is, the ability of the pathogen to cause severe harm or infection.

## **PURPOSE:**

The purpose of this policy is to provide staff with information on how to identify and report when information becomes known that a resident(s) may be infected with a pathogen that is highly transmissible and/or virulent and how to proceed. Suspected epidemics, outbreaks and clusters of healthcare associated infections shall be investigated completely and uniformly.

## **PROCEDURE:**

1. The neighborhood Charge Nurse (CN) is responsible for contacting the ~~Infection Control Nurse (ICN)~~ when there are two or more of a similar infection in a period of 72 hours occurring on the neighborhood or when there is a single case involving a highly transmissible and/or virulent pathogen.
2. The lead ~~(ICN)~~ shall determine whether the situation is an infectious outbreak and collaborate with the ICC Chair, ~~if necessary,~~ to determine whether the situation is an infectious ~~epidemic-outbreak or cluster~~ that poses a threat to the health and safety of residents and employees. Once the lead ICN and ICC Chair ~~,if necessary,~~ determines that an outbreak/~~epidemic~~ has occurred, the neighborhood and other appropriate individuals shall be notified, and an Unusual Occurrence (UO) report shall be submitted by the lead ICN.
3. If investigation indicates that an outbreak or epidemic exists, the ICN or designee shall notify the San Francisco Department of Public Health (SFPDH) Communicable Disease Unit and the Risk Management Nurse shall notify ~~the California Department of Public Health~~ CDPH when appropriate.
- 3.4. The ICN ~~nurse~~ and ICC Chair will remain in contact with local and state departments for similar outbreaks in the surrounding areas. The ICN nurse will work in conjunction the local health department investigations for contact tracing and implement recommendations to prevent further transmission.

~~Key players shall be selected to participate in the planning process for control of the outbreak, including the utilization of the Hospital Incident Command System, if necessary. Such individuals may include any or all of the following:~~

~~4.5. An interdisciplinary team will be convened to provide a rapid response to the outbreak including the ICN team members. If the outbreak involves a high potential for morbidity and/or mortality based upon the local, state, and/or federal health departments, the **HazardousHospital** Incident Command System (HICS) shall be initiated. The HICS ~~team~~ Incident Commander will determine membership of their team, assign roles in the HICS structure, and include subject matter experts as needed. may include but are not limited to the following departments/roles:~~

~~a. Chair of the Infection Control Committee~~

~~\_\_\_\_\_~~

~~b. Infection Control Nurse(s)~~

~~\_\_\_\_\_~~

~~c. Chief Medical Officer~~

~~\_\_\_\_\_~~

~~d. Chief Nursing Officer~~

~~\_\_\_\_\_~~

~~e. Industrial Hygienist/Safety Officer~~

~~\_\_\_\_\_~~

~~f. Other Infection Control Committee members~~

~~\_\_\_\_\_~~

~~g. Nurse Manager of the involved resident care neighborhood(s)~~

~~\_\_\_\_\_~~

~~h. Physician of the involved resident care neighborhood(s)~~

~~\_\_\_\_\_~~

~~i. Program Director of Nursing or designee~~

~~\_\_\_\_\_~~

~~j. Occupational Health Service Director or designee~~

~~\_\_\_\_\_~~

~~k. Clinical Microbiology Laboratory manager and personnel~~

~~\_\_\_\_\_~~

~~l. Director of Pharmacy or designee~~

~~\_\_\_\_\_~~

~~m. Hospital Administrator or designee~~

~~\_\_\_\_\_~~

~~n. Department of Public Health representatives from appropriate communicable disease division(s)~~

~~4.6. The HICS Incident Commander~~The ICN(s) Infection Control Nurse(s) ~~may call an immediate meeting of such individuals and disciplines to:~~

~~a. Clarify the nature and extent of the potential problem.~~

~~b. Discuss proposed investigative steps.~~

- c. Determine and assign responsibility of each department; determine who shall collect and record specific data.
- d. Anticipate questions that may arise and develop a frequently asked question (FAQ) fact sheet.

~~5.7.~~ Major ~~Decisions~~ involving a major disruption of services affecting large numbers of residents, personnel, or considerable expense (such as "closing" a neighborhood), shall be made in conjunction with the investigating personnel, attending staff, and administration.

~~6.8.~~ In the event that ~~if~~ prophylactic or therapeutic medication is required for residents, the prescribing physicians shall be notified by the ICC Chair.

~~7.9.~~ Frequent interdisciplinary meetings or "huddles" may be held to review and plan for new developments. The frequency of interdisciplinary meetings will be determined on a case-by-case basis

~~8.10.~~ The ICN shall collaborate with clinical members of the ICC to write the investigation report and distribute the report to involved departments. Communication with upline and downline stakeholders will be developed either by the HICS incident command team and/or in conjunction with the ICN and ICC Chair and provided on a regular basis.

~~9.11.~~ After the investigation is completed, the ICC shall critically review all aspects of the investigation in order to identify problems that could be averted in the future. A summary of the investigation will be provided by the ICC to the QAPI/Risk Committee for follow up. Recommendations will be reviewed for implementation.

~~10.12.~~ Refer to Standard Work and protocols for the prevention and management of influenza and norovirus outbreaks on LHH intranet under Infection Control.

#### **ATTACHMENT:**

None.

#### **REFERENCE:**

CDPH AFL 19-18 REQUIREMENTS TO REPORT OUTBREAKS AND UNUSUAL INFECTIOUS DISEASE OCCURRENCES  
([HTTPS://WWW.CDPD.CA.GOV/PROGRAMS/CHCQ/LCP/CDPD%20DOCUMENT%20LIBRARY/AFL-19-18.PDF](https://www.cdpd.ca.gov/programs/chcq/lcp/cdpd%20document%20library/afl-19-18.pdf))  
CENTERS FOR DISEASE CONTROL ([HTTP://WWW.CDC.GOV](http://www.cdc.gov))  
LHHPP 70-01 B1 Emergency Response Plan  
LHHPP 70-01 C5 Emergency Responder Antibiotic Dispensing Plan  
LHHPP 72-01 A9 Contact/Exposure Investigation

LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions  
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis  
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 2014/11/25, 2019/03/12, 2019/07/09, 2020/06/16 (Year/Month/Day)  
Original adoption: Est. 2005/11/01s



## CONTACT/EXPOSURE INVESTIGATION

### POLICY:

1. Laguna Honda Hospital will implement as protocols for contact and exposure investigation for the purpose of contact tracing for an outbreak and/or exposure investigation.
2. The Infection Control Nurse (ICN) is responsible for conducting contact/exposure investigation when a resident(s) is suspected to have been in contact or exposed to a communicable disease.
3. Not every infection requires a contact exposure investigation. The determinate factor(s) include but are not limited to the organism involved, the rate and mode of transmission of the pathogen, the at-risk population, whether a cluster or outbreak is occurring in the community, the morbidity and mortality rates and whether current tests and treatment are available. Some infections such as measles, tuberculosis (TB), and Coronavirus Disease 2019 (COVID-19) are highly transmissible and can have severe outcomes if left unchecked. Other infections can be treated at the source to reduce the potential of spreading to others using sStandard and/or tTransmission-based precautions.
4. LHH will protect resident privacy during the investigations by only informing contacts that they may have been exposed to-a someone with the infection. They are not told the identity of the person who may have exposed them.
5. In addition to health care staff, the ICNP will assess interactions between residents and all staff, including but not limited to activity coordinatorstherapists, food service staff, and sanitation management.

### DEFINITIONS:

- Contact tracing:- is part of Tthe processprocesses of supporting patientsresidents with suspected or confirmed infection. The ICN team membersP staff will work with a patientresident to help them recall everyone with whom they have had close contact during the timeframe while they may have been infectious.
- Close contact: based on the Centers for Disease Control and Prevention (CDC) defines as's definition, is someone who was within 6 feet of an infected person for at least 15 minutes starting from 48 hours before illness onset until the time the resident is isolated.
- High-risk Eexposure-high risk: Ccontact with someone who is infected with a highly transmissible pathogen, that if exposed could quickly spread to a vulnerable population quickly and cause high levels of morbidity and/or mortality

2. ———

## PURPOSE:

The purpose of this policy is to provide guidance and direction for evaluating and managing exposures or potential exposures of residents in the facility for the purpose of diagnosis, treatment, and isolation in order to prevent the transmission of the disease to others.~~To evaluate and manage residents who have been exposed to infectious diseases while in the facility.~~

## PROCEDURE:

1. Contact investigations are conducted to evaluate contacts for immunity, prophylaxis, isolation or precautions, as indicated by specific diseases to prevent spreading the disease to others~~secondary cases~~.
- ~~2. In some infectious disease circumstances, prompt prophylaxis is required and more immediate notification may be necessary. The Infection Control team will make this determination at the time. Under these circumstances, all components of this policy may not be possible and phone calls, verbal instructions, etc., will be substituted.~~Once a resident has been determined to be exposed to a contagious or potentially contagious pathogen, the ICN team will be notified **immediately no later than 24 hours after the exposure is identified**. Prompt initiation of prophylaxis and/or quarantine may be required for some exposures. Document all healthcare worker contacts.
- ~~2.3. Time is critical to the contact investigation to identify and/or remove the potential infection source. Identifying contacts and ensuring they do not interact with others is critical to protect communities from further spread.~~
4. Contact investigations are initiated immediately when an infectious pathogen is known. The first step is to isolate the source of the pathogen away from others. This may include isolation of resident(s) who is/are known to be infectious. Depending upon the pathogen's method of transmission, this may include but is not limited to placing a surgical mask on the resident (if medically appropriate), covering open wounds to limit drainage, closing the door to the room, closing the curtain and/or moving the roommate(s) to another room. The ICN will be contacted for isolation guidance by the Infection Control Nurse during business hours and by the Nursing Operations Manager during off-business hours for exposures to cases of:  
  
~~— Once the source of the infection is isolated, the Infection Control Nurse will be notified to begin the contact investigation.~~
- ~~3.5. Contact investigations will be initiated for the following high-risk exposures:~~
  - a. Sudden active respiratory syndrome coronavirus 2 (SARS-CoV-2) or the virus that causes COVID-19

~~a.b.~~ Active pulmonary tuberculosis

~~b.c.~~ Rubella (German measles)

~~c.d.~~ Rubeola (measles)

~~d.e.~~ Varicella (chicken pox)/-disseminated varicella

~~e.f.~~ Meningococemia/ meningococcal meningitis

~~f.g.~~ Pertussis

~~g.h.~~ Invasive ~~Hemophilus~~ influenza disease

~~h.i.~~ Norwegian scabies

~~i.j.~~ Any other highly communicable diseases as determined by the local or state health department~~needed~~

~~4.6. In the event a contact investigation is required, the ICN initiates the protocol investigation for contact investigations~~ as follows:

~~a. Confirms the diagnosis and defines the disease-specific exposure based on current Centers for Disease Control (CDC) criteria that a communicable disease exposure has occurred by reviewing the electronic medical record for confirmation that a communicable disease is/was present at the time of exposure. Determine if an outbreak is occurring by verifying the diagnosis.ia.~~

~~Note: If it is determined that no exposures occurred, the person(s) suspecting the exposure is notified.~~

~~b. Interview the resident or resident representative to determine the scope of the exposure (time, closeness, contacts, etc.). Potential sources may include Reviews the infectious resident's chart(s) and/or interviews the source(s) to determine who was exposed. Possibilities include:~~

- ~~i. Persons within departments with whom the resident had contact~~
- ~~ii. Other residents with whom the source had contact~~
- ~~iii. Family members and community contacts whom the source exposed~~

- c. Interviews employee and/ or the manager to determine if the contact/source is an employee.
- d. Informs the Chair of the Infection Control Committee, the Employee Health Service, the Industrial Hygienist from the department of Workplace Safety and Emergency Management (WSEM), and the appropriate public health communicable disease division.
- e. Notifies the department directors/managers involved, provides the exposure definition, dates of exposure, and name of the index case/source when appropriate.
- f. Determines if other residents were exposed ~~according to the exposure definition (by applying the exposure definition).~~
- ~~f.g.~~ In the event of an extensive contact investigation involving many resident units/neighborhoods or services, as determined by the ~~Infection Control Professional~~ ICN team, a multi-disciplinary team will be assembled to determine the specific course of action

**~~NOTE: In the event of a complicated or extensive contact investigation involving many resident units or services, as determined by the Infection Control Professional, a multi-disciplinary team will be assembled to determine the specific course of action.~~**

#### 5.7. Contact Investigation Protocol for Exposed Residents:

- a. The ICN develops a contact list of exposed residents and notifies the Chief Medical Officer and Chief Nursing Officer.
- b. A line listing is initiated by the ICN to identify and document resident symptoms, movement, treatments, diagnostics, and testing. This list is reviewed and updated daily by the ICN to determine if the pathogen is being transmitted to others and the information is shared with providers and quality risk managers.
- ~~a.c.~~ In the event that an outbreak progresses to the epidemic and/or pandemic state, the Hazardous Incident Command System (HICS) will be initiated. Information from the contact listing will be shared with this team until the situation as resolved
- ~~b.d.~~ For residents ~~still~~ in the facility, the ICN shall notify the physician of the exposure and required follow-up ~~for that may include prophylaxis treatments.~~
- ~~c.e.~~ For cases involving ~~discharged~~ resident exposure to ~~local health department~~ Communicable Disease Unit (CDU) reportable infections, ~~a list is forwarded to the appropriate Department of Public Health Communicable Disease Division~~ the facility and local health department will ~~for~~ assistance in contacting

~~discharged~~ residents. The ICN, Social Services, and local health department shall coordinate ~~with Department of Public Health Communicable Disease Division~~ to ensure the resident is notified.

~~6.8.~~ Contact investigation for exposed employees shall be conducted by Employee Health and Workplace Safety and Emergency Management. Please refer to LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

~~7.9.~~ Upon completion of the ~~c~~Contact ~~i~~nvestigation, the Infection Control Committee (ICC) shall determine if the resident/employee exposures could have been prevented. If determined to be avoidable, remediation in the form of a follow-up letter and/or educational program will be instituted. A summary of the investigation will be forwarded to the QAPI committee, including the Chief Medical Officer and Chief Nursing Officer for follow up.

**ATTACHMENT:**

None.

**REFERENCE:**

Centers for Disease Control (CDC)

~~<https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html>~~

San Francisco Department of Public Health ~~Communicable Disease Control Program (SFPDH CDCP)~~ Population Health Division Disease Prevention and Control (SFPDH)  
~~<https://www.sfcdcp.org/>~~

LHHPP 72-01 A8 Outbreak Investigation Protocol

LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis

LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 2014/11/25, 2018/09/11, 2019/05/14, 2020/06/16 (Year/Month/Day)

Original adoption: Est. 2005/11/01

## CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE EQUIPMENT

### POLICY:

Laguna Honda Hospital [and Rehabilitation Center](#) (LHH) staff is responsible for routine cleaning and disinfection of non-critical resident care equipment according to established facility procedures [and manufacturer guidelines](#).

### PURPOSE:

To minimize the risk of transmission of pathogens during use of non-critical resident care equipment.

### DEFINITION:

**Non-critical** ~~is the classification level given to resident care equipment includes items that does not come into contact with any sterile body cavity or mucous membrane. Non-critical resident care equipment requires low level disinfection procedures between resident use. Such items may include but are not limited to blood pressure cuffs or pulse oximeters in which the intact skin serves as an effective barrier to pathogens. intact skin but not mucous membranes. Intact skin is an effective barrier where sterility of the equipment is not critical.~~

The **standard hospital-wide approved disinfectant** ~~are~~ [hydrogen peroxide-based disinfectant wipes](#). [These](#) shall be used for cleaning and disinfecting non-critical resident care equipment unless otherwise noted in attachment LHH Non-Critical Resident Care Equipment Disinfectant Exceptions.

The ~~standard~~ [sodium hypochlorite \(bleach\)](#)-based [\(bleach\)](#) disinfectant wipe must be used for disinfection of equipment used by residents infected with pathogens that cannot be killed with hydrogen peroxide, such as *Clostridioides difficile* (*C. diff.*).

**Dedicated equipment:** [Any medical equipment that will be used by a single resident and is not shared with other residents for the duration of the prescribed treatment.](#)

**Multi-resident use equipment:** [Shared equipment used for multiple residents for care when intact skin will provide a sufficient barrier. Shared equipment is cleaned and/or disinfected after each resident use.](#)

**Minimum contact time:** [Time required to effectively render the pathogen inactive and not capable of being transmitted to others. Contact time is determined and listed on the product label.](#)

~~Non-critical equipment includes items such as a bed alarm, bladder scanner, blood pressure machine (Dynamap or Welch Allyn), blood pressure cuff (DURA-CUF), crash cart, doppler, ECG machine, feeding pump, glucometer, gurney, hypothermal machine, infusion pump, isolation cart, nebulizer machine, patient-controlled analgesia (PCA), pulse oximeter, stethoscopes, suction machine, tympanic thermometer, and wheelchairs.~~

## PROCEDURE:

~~1. A hospital-approved phenolic-based, sodium hypochlorite (bleach) based or quaternary ammonium-based compound hospital disinfectant, which also contains a detergent so it both cleans and disinfects shall be used for the purpose of cleaning and disinfecting non-critical resident care equipment. Hospital approved ready-to-use pre-saturated "wipes" are available and accessible for staff use throughout the facility (i.e. currently green top wipes). A bleach based disinfectant must be used for disinfection of equipment used by residents infected with *Clostridium difficile*.~~

~~1. Clinical care personnel~~Multi-resident use equipment is cleaned and/or disinfected after each resident use, shall have the responsibility of cleaning and disinfecting equipment that is used between residents.

a. Perform hand hygiene and don clean gloves.

b. Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet.

c. Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection.

~~2.~~d. Remove gloves, perform hand hygiene.

2. Dedicated equipment is cleaned daily and as needed by Nursing staff to reduce the spread of pathogens while in use. Single use or dedicated equipment used for one resident is obtained from Central Processing Department (CPD) when first ordered for the resident~~The following non-critical care equipment are dedicated for use by one resident for the duration of the prescribed treatment.~~

• ~~crash cart~~

• ~~doppler~~

• ~~feeding pump~~

• ~~hypothermal machine~~

• ~~infusion pump~~

• ~~isolation cart~~

• ~~nebulizer machine~~

• ~~PCA~~

• ~~suction machine~~

a. Perform hand hygiene and don clean gloves.

b. Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet.



c. Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection.

d. Remove gloves, perform hand hygiene.

~~(CPD) These items are obtained from Central Supply when first ordered for the resident. Nursing staff is responsible for cleaning the equipment daily~~

~~Perform hand hygiene and don clean gloves.~~

~~Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet~~

~~Refer to attachment LHH Non-Critical Resident Care Equipment and Compatible Disinfectants on disinfection frequency of certain parts of equipment such as the metal basket in the vital signs machine.~~

~~Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection.~~

e. ~~Remove gloves, perform hand hygiene, and as needed while in use by the one specific resident. At the conclusion of the prescribed treatment, any disposable tubing, cuff/attachment, and devices are is discarded, and the equipment is disinfected by Nursing staff prior to being returned picked up to by Central Processing Department Supply CPD. CPD will then perform the for necessary cleaning, and disinfection, and preventive maintenance before placing the equipment into their inventory issued to another resident or returned to the vendor.~~

3. In the event the standard hospital-wide approved disinfectants are not immediately available, equivalent products may be considered when in compliance with Biomed, the Safety Officer, and Infection Control Nurse to ensure the product meets manufacturer's guidelines and does not damage equipment.

a. Changes in disinfectant product(s) shall be communicated to staff using the new product(s) through methods such as electronic learning modules, memorandums, and in-services.

## **ATTACHMENT S:**

1. LHH Non-Critical Resident Care Equipment Disinfectant Exceptions ~~None.~~

2. Standard Work Single-Resident Blood Pressure P-Cuffs Standard Work

## **REFERENCE:**

LHHPP 72-01 Infection Control Manual, E4 Central Supply / Materials Management

APIC Guideline for Selection and Use of Disinfectants, 1996

APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996.

The Association for the Advancement of Medical Instrumentation.

Revised: 2011/2005, 2012/05/22, 2016/01/12, 2020/06/16 (Year/Month/Day)

Original adoption: Est. 2005/11/01



## Attachment: LHH Non-Critical Resident Care Equipment Disinfectant Exceptions

**Instructions:** Use the standard hospital-wide approved disinfectant for all non-critical resident care equipment with the exception of the following equipment listed below.

Equipment	Compatible Disinfectants	Contact Time
Glucometer (Accu-Check Inform II)	PDI Super Sani-Cloth Germicidal Disposable Wipe	2 minutes
Thermometer (Bliss Non-Contact Infrared Thermometer)	70% isopropyl (alcohol wipe or spray)	Visibly wet until dry
Thermometer (Cardinal Health Genius 3 Tympanic Thermometer)	70% isopropyl (alcohol wipe or spray)	Visibly wet until dry



## Title: Single-resident Blood Pressure (BP) Cuffs

Performed By: Nurse, CNA, any staff taking a resident's BP

Revision Date:

Date First Created: 5/15/20

Owner: Nursing

Revised By: Dauterman, Yu

Revision #: 1

**Purpose:** To ensure that staff members have PPE necessary for resident care, while mitigating the risk of running out of PPE supplies.

Major Steps		Detail(s)	Diagram, Work Flow, Picture, Time Grid										
1.	PROVIDE RESIDENT WITH THEIR OWN BP CUFF	<ul style="list-style-type: none"><li>Each resident is provided a BP cuff that will be specifically for them</li><li>1. A new BP cuff is provided to each resident at admission or transfer to LHH and as needed to replace the BP cuff due to damage, loss, or changes to the resident's body size</li><li>2. Determine the appropriate size cuff - see table and instructions →</li><li>3. Write resident's name in permanent marker on the outside of the cuff</li></ul>	<p>➤ Use information below to determine cuff size*</p> <table><thead><tr><th>Arm circumference</th><th>BP cuff size</th></tr></thead><tbody><tr><td>22-26 cm</td><td>12x22 cm = SMALL</td></tr><tr><td>27-34 cm</td><td>16x30cm = ADULT</td></tr><tr><td>35-44 cm</td><td>16x36cm = LARGE</td></tr><tr><td>45-52 cm</td><td>16x42 cm = XL/THIGH</td></tr></tbody></table> <p><small>* Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research. Recommendations for blood pressure measurement in humans and experimental animals. Part 1: measurement in humans. Hypertension 2005; 45:142–61.</small></p>	Arm circumference	BP cuff size	22-26 cm	12x22 cm = SMALL	27-34 cm	16x30cm = ADULT	35-44 cm	16x36cm = LARGE	45-52 cm	16x42 cm = XL/THIGH
Arm circumference	BP cuff size												
22-26 cm	12x22 cm = SMALL												
27-34 cm	16x30cm = ADULT												
35-44 cm	16x36cm = LARGE												
45-52 cm	16x42 cm = XL/THIGH												
2.	STORAGE OF RESIDENT-SPECIFIC BP CUFFS	<ul style="list-style-type: none"><li>Use a brown paper bag with the resident's name written on it in permanent marker</li><li>Store bag in resident's room</li><li>Return BP cuff to brown paper bag and storage place in resident's room after each use</li></ul>	<p>➤ A brown paper bag allows the BP cuff to dry out in the event that it becomes damp with use (i.e. sweat)</p> <p>➤ Replace brown paper bag if it becomes soiled, wet, contaminated, or worn out</p> <ul style="list-style-type: none"><li>○ Tear off portion of the bag with resident's name and discard in a designated shredding bin as the resident's name is protected health information</li></ul>										
3.	MANAGING RESIDENT-SPECIFIC BP CUFFS	<ul style="list-style-type: none"><li>The resident's designated BP cuff is stored in a brown paper bag in their room</li><li>Disinfect the BP cuff tube after each time it is used and disconnected from the tubing on the VS machine</li></ul>	<p>➤ Do not use a resident's BP cuff on another resident</p> <p>➤ Do not allow a resident's BP cuff to come in contact with another resident's BP cuff</p>										
4.	WHEN TO DISCARD AND REPLACE THE RESIDENT'S BP CUFF	<ul style="list-style-type: none"><li>Discard and replace the resident's BP cuff when:<ul style="list-style-type: none"><li>○ Worn out or tattered</li><li>○ Visibly soiled</li><li>○ After the resident has recovered from an active infection (i.e. flu, C. diff, Norovirus, etc)</li></ul></li></ul>	<p>➤ Resident's name must be marked out with a permanent marker prior to discarding the BP cuff as the resident's name is protected health information</p>										

# **Revised Nursing Policies and Procedures**

## DOCUMENTATION OF RESIDENT CARE **by** NURSING ASSISTANT

### POLICY:

1. Nursing Assistant (CNA and PCA) documents activities of daily living (ADL) in the ADL section of the electronic health record (EHR).
2. Daily Cares are completed near the end of each shift by nursing assistant (CNA and PCA).
3. Nursing Assistant documents intake and output in the I/O Flowsheet of the EHR. (Reference I&O Policy).
4. Nursing Assistant documents change in condition in the Notes section of the EHR and notifies the charge nurse or the licensed nurse.

### PURPOSE:

Concise and accurate documentation and monitoring of daily care provided.

### INTRODUCTION:

I/O Flowsheet

ADLs

Daily Cares

Flowsheet

- PCA Vitals, I/O

- PCA Daily Cares/Safety

i. PCA/CNA will also document Restorative Interventions in this section

Coach Doc

Notes

### PROCEDURE:

#### A. I/O FLOWSHEET (Refer to NPP G3.0 Intake and Output for details on documentation)

Document resident's intake and output for the following:

- Percent Meals Eaten (%)
- Urine Incontinence/Urine Amount/Unmeasured Urine Occurrence
- Bowel Incontinence/Unmeasured Stool Occurrence/Stool Amount/Stool Appearance:
- Colostomy/Ileostomy

NOTE: Licensed Nurse must document output for nephrostomy.

#### B. ACTIVITIES OF DAILY LIVING ACTIVITY TAB

ADL Activities:

- i. **Eating:** How resident eats and drink, regardless of skill. Do not include eating/drinking medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).
- ii. **Dress:** How resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.
- iii. **Toilet:** How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Does not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.
- iv. **Personal hygiene:** How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes bath and showers).
- v. **Bathing:** How resident takes full-body bath/shower or sponge bath, including transfers in/out of tub/shower. Does not include washing of back or hair.
- vi. **Bed Mobility:** How resident moves to and from lying position, turns side to side, and positions body while in bed. Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when documenting bed mobility.
- vii. **Transfer:** How resident moves between surfaces and positions. Includes to/from the bed, a chair, a wheelchair, and standing. Excludes to/from the bath and toilet.
- viii. **Walk in room:** How resident walks between locations in their room
- ix. **Walk in the hall:** How resident walks in the hallway on unit
- x. **Locomotion on unit:** How resident moves between locations in their room and adjacent hallway on the same floor. If in wheelchair, self-sufficiency once in chair
- xi. **Locomotion off unit:** How resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

#### **A. GENERAL GUIDELINES:**

1. ~~Nursing Assistant documents in the electronic health record selecting the correct coding.~~
- a. ~~Activities of Daily Living (ADL) self-performance indicates the actual resident performance, not resident capability.~~
- b. ~~ADL support indicates the highest level of support and number of staff provided during the shift as listed on the form.~~
- c. ~~Definitions are as follows:~~

##### Self-Performance:

- ~~Independent – No help or staff oversight anytime.~~
- ~~Supervision – Oversight, encouragement or cueing provided.~~

##### Support Provided:

- ~~Limited Assistance – Resident highly involved in the activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance.~~
- ~~Extensive Assistance – Resident involved in activity, staff provide weight bearing support~~
- ~~Total Dependence – Full staff performance of the activity for the entire shift. Complete on-participation by the resident in ALL aspects of the ADL definition.~~
- ~~Activity did not occur – The ADL activity was not performed by the resident or the staff during the observation period. The activity did not occur at all.~~

#### **B. CODING**

See Appendix 1 for coding data definitions.

### **C. DAILY CARES ACTIVITY TAB**

Document only once every shift:

- Repositioned: Select all positions provided during the shift
- Positioning Frequency: Select "Every 2 hours" unless otherwise ordered by the physician.
- Hygiene: Select all hygiene care provided during the shift

### **D. FLOWSHEET ACTIVITY TAB**

- **PCA VITAL SIGNS, I/O** (Refer to NPP G3.0 Intake and Output for details on documentation):
  - i. Document:
    1. Vital Signs
    2. Height/Weight
    3. Measured Intake/Output
- **PCA Daily Cares/Safety**
  - ii. PCA/CNA documents restorative interventions in this section Document the following:
    1. Type of restorative activity under the appropriate section
    2. Minutes spent on each restorative category under Restorative Nursing Program

### **E. RESTORATIVE INTERVENTIONS**

See above (Section D. Flowsheet Activity Tab)

### **G.F. NOTES ACTIVITY TAB**

Use the Notes section to document any supplemental data not noted in other areas (e.g., licensed nurse notifications, changes in condition).

### **~~D. NOTE: There may be additional flowsheets to document in as needed (e.g., Coach Documentation, Restraints, etc.)~~VITAL SIGNS**

~~Use Vital Signs section to document resident's Vital Signs and height/weight~~

### **~~E. I/O Flowsheet~~**

~~Use the I/O Flowsheet section to document resident's intake and output~~

### **~~F. ADLs~~**

~~Use ADLs section to document resident's activities of daily living (including eating, dressing, toilet use, personal hygiene, bathing, bed mobility, transfer, walk in room, walk in hall, locomotion on unit, and locomotion off unit)~~

**~~G. DAILY CARES~~**

~~Use Daily Cares section to document any additional interventions (e.g., skin care, restorative, hygiene, risks).~~

\_\_\_\_\_

**REFERENCES:**

RAI/MDS Manual

**APPENDIX I: DNCR Coding Tables**

Adopted from Policy Number Changed from C 3.1 to C 3.2, September, 2009

Revised: 2002/08; 2009/03; 2014/07/22, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

**APPENDIX I: ADL CODING TABLES**

**ADL CODING**

		<b>DID NOT TOUCH RESIDENT</b>	<b>TOUCHED RESIDENT</b>	<b>ACTIVITY DID NOT HAPPEN</b>
<b>BATHING</b>	<b>Self-Performance</b>	<b>0</b> = Independent  <b>1</b> = Supervision or Cueing	<b>2</b> = Physical help only for transfer  <b>3</b> = Physical help in part of bathing  <b>4</b> = Total dependence— the resident did not help out at all for the entire bath  <b>(DO NOT INCLUDE THE ASSISTANCE PROVIDED WITH WASHING HAIR &amp; BACK)</b>	<b>X</b> = Bathing did not occur at all for the <u>entire</u> 8-hour shift
	<b>Support Provided</b>  <b>NOTE:</b> Code the highest level of support provided	<b>0</b> = No set-up or physical help needed from staff  <b>S</b> = Set up help only	<b>1</b> = 1 person physical assist  <b>2</b> = 2 person physical assist  <b>(If more than 2 person, list # of staff who assisted)</b>	<b>X</b> = No support provided for the <u>entire</u> 8-hour shift

**APPENDIX I  
DNCR CODING TABLES CONTINUED**



## APPENDIX I: ADL CODING TABLES

### ADL CODING

If answer for whether an activity occurred is “yes,” select the amount of assistance the resident required; if no/refused, document reason in the comment field.

#### Self-Performance:

- Didn't need help: Resident did not need help completing the activity
- Setup help only: Resident was given proper materials to complete the activity on their own
- Physical help from me: Resident required one person to help perform the activity
- Physical help from me and another person: Resident required more than one person to help perform the activity

#### Support Provided:

- Supervision – Includes oversight and verbal encouragement or cueing.
- Limited help – Resident needed guidance in movements
- Extensive help – Resident needed to be supported throughout the activity
- Total Dependence – Resident was not able to contribute to the activity

Document the following only if “Physical help from me” or “Physical help from me and another person” is selected:

#### Physical Support Provided for Transfer/Walking/Locomotion:

- Non-weight-bearing help: Resident needed guidance in movements
- Weight-bearing help: Resident needed to be supported throughout the activity
- Total dependence: Resident was not able to contribute to the activity

#### Physical Support Provided for Bathing

- Physical help limited to transfer only: Resident performed the bathing activity, but required help with the transfer only
- Physical help in part of bathing activity: Resident required assistance with some aspects of bathing. Does not include washing of back or hair
- Total Dependence: Resident was not able to contribute to activity

### NOTES:

For Eating: If resident has a feeding tube, IV for hydration or TPN document:

- “Yes”
- “Physical help from me and another person”

For: Toilet Use: If resident has a catheter or ostomy for stool, document:

- “Yes” if output present
- “Physical help from me and another person”

## APPENDIX I DNCR CODING TABLES CONTINUED

BOWEL (If have colostomy, write “Col” on the side of “Bowels” but still code as below)			BLADDER	If NO catheter	If catheter present
TOP ROW	X = No BM	C = Continent	TOP ROW	C = Continent –	F = Foley

		(Include colostomy did not leak)  <b>I = Incontinent</b> (skin was wet with BM – can be a little or a lot; include if colostomy leaked)		(skin is not wet)  <b>I</b> = Incontinent – (skin is wet)  <b>X</b> = Did not void	<b>SC</b> = Supra Pubic Catheter  <b>CC</b> = Condom Catheter  <b>N</b> = Nephrostomy  <b>U</b> = Urostomy
<b>BOTTOM ROW</b>	<b>0 = Zero # of BM</b>	<b>#of BM</b>  <b>/</b> <b>SM</b> = Small <b>M</b> = Medium <b>LG</b> = Large <b>H</b> = Hard <b>R</b> = Runny	<b>BOTTOM ROW</b>	<b># of times voided as continent or incontinent</b>	<b># of times catheter leaked</b>
<p align="center"><b><u>MEAL INTAKE:</u></b>  <b>R (&lt;25%), 25%, 50%, 75%, or 100%</b>  <b>If ate less than these, code for the lower percentage.</b>  <b>(do not code any % if on tube feedings ONLY)</b></p>					

## TRANSCRIPTION AND PROCESSING OF ORDERS

### POLICY:

1. In the event of a downtime, refer to (Appendix 1: How to carry out written orders).
- 4.2. Licensed nurses (RN, LVN) are responsible for ~~the review, transcription and processing of~~ acknowledging orders prescribed on their shift.
- 2.3. Incomplete, questionable or confusing orders are clarified with the prescriber and if appropriate, pharmacy, prior to implementation ~~or processing~~ for resident/patient safety. The Nurse Supervisor/Manager on duty should be called if the clarification has not remedied the licensed nurse's concern.
3. Medication-Physicians orders are accepted electronically, ~~in writing, and by~~
3. ~~telephone or verbal order directly from an authorized prescriber as outlined in LHHPP 25-03 Verbal Telephone Medication Orders.~~
4. Telephone and verbal orders are used only when absolutely necessary, ~~written down~~ and then read back by the recipient, and confirmed or corrected by the prescriber. Refer to LHHPP 25-03 Verbal Telephone Medication Orders.
5. The following providers are authorized to give verbal orders:
  - a. ~~Physician~~
  - b. ~~Affiliated Health Care Practitioner credentialed by the medical staff~~
  - c. ~~Dentist~~
  - d. ~~Pediatrist~~
6. ~~The following job classes are authorized to accept verbal orders:~~
  - a. ~~Licensed Nurse (LN)~~
  - b. ~~Licensed Pharmacist~~
  - c. ~~Licensed Rehabilitation Therapist~~
  - d. ~~Respiratory Therapist~~
  - e. ~~Clinical Dietitian~~
- 7.6. Each resident's orders are reviewed monthly by the physician and the licensed nurse.
- 8.7. All residents' charts are reviewed nightly by A.M. (night) shift LN. ~~to verify that all orders for the previous twenty four (24) hour period have been noted and processed.~~

### PURPOSE:

To assure that orders are accurately and appropriately transcribed and processed.

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### PROCEDURE:

**A. Nursing Orders**

1. ~~To initiate a nursing order record the date, time and the phrase "nursing order" or "N.O" followed by the order and legible signature and title. Nursing orders shall be placed in the Worklist.~~

**C. Telephone or Verbal Orders**

1. See Hospital wide Policy 25-03 for Verbal/Telephone Orders

**D. Processing Orders to Pharmacy**

1. E-prescription by the physician will be sent electronically by the EHR to the Pharmacy.

**E. "STAT" Orders & Pharmacy Response Time**

1. STAT labs: STAT Courier is called for immediate pick up if pick up of is not near time collection.

2. NOW Labs: Labs will go out the next scheduled courier pick up

4.3. Nursing and pharmacy shall process stat orders immediately during regular pharmacy hours. Outside of pharmacy hours STAT orders are obtained by ~~Operations~~-Nurse Operations Manager/Supervisor refer to Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies.

2.4. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered "STAT" which are available in the unit emergency drug box shall be administered immediately.

3.5. New orders for anti-infectives and medications that are used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

4.6. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

**F. Discontinued Medication Orders**

1. Refer to NPP J1.1 for Obtaining, Handling, Storing of Medications.

**G. Monthly review of Printed Physician's Order Sheets:**

1. The physician reviews medication orders monthly and documents the review in the EHR.
- ~~2. A new, blank POS is to be inserted for writing the new orders after the copies have been pulled.~~
- ~~3. The following month's orders, MAR and TAR are printed and delivered to each unit before the end of the month.~~

**H. Nightly Verification of Order Processing and Transcription by A.M. Shift Licensed Nurse**

1. Licensed Nurses will review the EHR ~~progress note~~ for each resident for new orders in the past 24 hours. (possibly document in flowsheet, base on nightly check process)

- ~~2. The LN verifies that each order in the EHR in the past 24 hour period was noted and transcribed in the MAR/TAR, etc.
  - ~~a. If the order has not been noted, the A.M. LN will transcribe and carry out the order.~~
  - ~~b. If the LN is unable to carry out an order, s/he will consult with the Nursing Operations Manager/Supervisor about any necessary remedial action. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.~~~~
- ~~3. If the A.M. LN discovers an error in the transcribing of the order, s/he must immediately discontinue the erroneous entry on the MAR by using the "Discontinuing an Order" as per above. Then the LN rewrites the entry accurately per the MD order. If a medication error has been made, Operations Nursing Manager/Supervisor must be contacted and an Unusual Occurrence completed. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.~~
- ~~4. Once the LN confirms that all orders have been accurately transcribed and carried out from both the EHR and the POS, the LN:
  - ~~a. For EHR, the LN signs/notes in the EHR that the 24 hour check was completed.~~~~

**CROSS REFERENCE:**

Hospitalwide Policy and Procedure  
25-02 Safe Medication Orders  
25-03 Verbal Telephone Medication Orders

Nursing Policy and Procedure  
J 1.0 Medication Administration  
J 1.1 Obtaining, Handling and Storing of Medications

Pharmacy Policy and Procedure  
02.03.00 Emergency and Supplemental Medication Supplies

Revised: 2001/08, 2006/04, 2006/12, 2008/03, 2008/08, 2010/10, 2014/02, 2015/07/14, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

## INTAKE AND OUTPUT (I & O)

### POLICY:

1. In addition to when ordered by the physician, intake and output (I&O) may be initiated by the Licensed Nurse (LN) when clinically indicated.
2. Intake and output are measured for residents ~~at risk for fluid imbalance; while~~ receiving intravenous therapy (NPP J 6.0 Intravenous Therapy Maintenance), including ~~peripheral parenteral nutrition (PPN) and~~ total parenteral nutrition (TPN) (NPP E 6.0 Total Parenteral Nutrition).
3. Intake is measured for resident receiving enteral nutrition and on fluid restrictions; output are measured ~~ed~~ based on clinical indication: (Refer to NPP E 5.0 Enteral Tube Feeding Management System).
4. Intake and output ~~are~~ measured every shift for all residents with a urinary catheter ostomy and/or has been diagnosed with a UTI.
5. Licensed nurse and/or nursing assistant records intake and output every shift.
- 5.6. Licensed nurse must document output for nephrostomy..

### PURPOSE:

To provide an accurate record of fluid intake and output as is necessary for the individual.

### PROCEDURE:

#### ~~A. Refer to Laguna Honda Hospital Nutrition Services Department Standardized Fluid Measurements~~

Item	Actual (Service) Volume (in ml)	Total Volume of the Container (in ml)
<del>Water Pitcher (to marker)</del>		800
<del>Soup bowl</del>	180	180
<del>Coffee Mug</del>	180	240
<del>Paper cup</del>	180	240
<del>Milk Carton</del>	240	240
<del>Prepackaged Juice</del>	120	120
<del>Ind. Canned Juice</del>	180	180
<del>Non-Dairy Creamer</del>	15	15
<del>Liquid Supplements</del>	240	240
<del>Ice Cream Cup</del>	-120	120
<del>Fruit Sorbet</del>	120	120
<del>Gelatin Cup</del>	120	120

#### ~~A. Documentation~~ **DOCUMENTATION:**

##### Location:

Documentation for intake/output shall be completed in two sections of the electronic health record:

1. I/O Flowsheet Activity Tab
2. PCA Vitals, I/O section within the Flowsheet Activity Tab

**Frequency:**

Documented for each occurrence separately:

- Percent meals eaten (%)
- Urine incontinence/urine amount occurrence (for residents who urinated in a toilet)
- Unmeasured urine occurrence (for residents who urinated in a protective undergarment)
- Voided urine
- Bowel incontinence/unmeasured stool occurrence
- Colostomy/ileostomy bag change (if present)
- Colostomy/ileostomy urine occurrence (if present)

The following can be documented at the end of each shift:

- Urethral/Urostomy sections if present (total output, securement method, bag change, treatment) – If bag changed more than once, may indicate multiple changes in the comment section of “Treatment”

1. Intake

- ~~If resident is on enteral nutrition, record intake in the electronic health record (EHR).~~

- ~~If resident is on fluid restrictions, receiving intravenous fluids for hydration or on parenteral nutrition, record intake in the electronic health record.~~

~~Note: For resident receiving I.V. fluids, Licensed Nurse will record the total amount infused and amount left in the bag in the I.V. Flow sheet (this is in addition to the documentation of intake in the EHR).~~

- c. ~~For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the care plan.~~

2. Output

- ~~Record output in the Intake and Output section of the EHR.~~

**I/O Flowsheet Activity Tab:**

Use the I/O Flowsheet section to document resident’s measured intake and output

**Percent Meals Eaten (%):** Document for all residents, if there is oral intake of food

**Unmeasured Urine Occurrence:** For residents who urinated in a protective undergarment.

**Urine Incontinence/Urine Amount:** For residents who urinated in a toilet. If no urine, leave “Urinary Incontinence” section blank

## **Intake and Output (I & O)**

**Bowel Incontinence/Unmeasured Stool Occurrence/Stool Amount/Stool Appearance:** For residents who had a bowel movement in a toilet and/or a protective undergarment

- If no stool, put "0" in unmeasured stool occurrence and leave "Bowel Incontinence" section blank

**Colostomy/Ileostomy:** PCA/CNA can only change the bag for a two-piece colostomy or ileostomy

- Document the following sections:
  - Bag change
  - Unmeasured stool occurrence

### **PCA Vitals, I/O section within the Flowsheet Activity Tab:**

#### **Intake**

- P.O. (mL): Oral intake only

#### **Output (mL):**

- Voided Urine (mL): Measured from a urinal or a urinary hat
- Urethral/Urostomy sections if present (If resident has a urethral catheter or urostomy present but there is no section to document on the electronic health record, inform Licensed Nurse).
  - Urethral Catheter:
    1. Collection Container
    2. Catheter Bag Changed
    3. Securement Method: Select "Securing Device" if a stat lock is used.
    4. Urine Output (mL)
  - Urostomy:
    1. Treatment
    2. Output (mL)

### **Care Planning**

For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the individualized resident care plan.

## **B. NotificationNOTIFICATION**

1. Notify physician for input and output monitoring initiated by nursing.
2. Notify physician for any clinical suspicion of inadequate I & O.
3. Notify dietitian when resident is placed or removed from fluid restriction.

## **REFERENCES:**

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



Nettina, S., (2010). *Lippincott manual of nursing practice*, (9<sup>th</sup> ed), Philadelphia, PA: Lippincott Williams & Wilkins

**CROSS REFERENCES:**

Nursing Policy and Procedure  
E1.0 Oral Management of Nutritional Needs  
E5.0 Enteral Tube Feeding Management  
E6.0 **Total** Parenteral Nutrition  
J6.0 Intravenous (I.V.) Therapy Maintenance

Revised: 2008/03; 2009/09; 2011/04/14; 2012/09/25; 2013/09/24; 2014/07/22; 2015/03/10; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12



# **New Rehabilitation Services Policies and Procedures**

## TREATMENT AUTHORIZATION REQUEST (TAR)

**PURPOSE:** To ensure that therapists provide accurate and timely information for Medi-Cal Treatment Authorization Requests (TAR's) for submission to the Medi-Cal office. In this policy the term "patients" also refers to residents in the Skilled Nursing Facility (SNF).

### PROCEDURE:

#### I. TAR COMPLETION

TARs must be completed for patients who have Medi-Cal or Medi-Cal pending at the time Occupational Therapy, Physical Therapy, or Speech-Language Pathology evaluations are performed. Each individual discipline must request authorization for treatments based on their plan of care within the rehabilitation treatment order. This order is submitted when requested via secure chat in the electronic medical record.

#### II. SPECIFIC SECTIONS of Rehabilitation Treatment Order

- A. The therapist completes a rehab treatment order including:
- The ICD 10 code with description.
  - Start of care date/ evaluation date to expected end date.
  - The specific procedure codes within the comment section.
  - Number of treatments requested.
  - Frequency and duration.
  - Location of services.
  - The therapist signs the rehab treatment order by "signing the visit".
  - The therapist selects- per protocol – "no cosign required" and identifies the referring provider.

#### III. TAR PROCESSING

- An electronic TAR is submitted after receipt of the rehabilitation treatment order

#### IV. TAR EXTENSIONS

- If the patient requires additional therapy beyond what was originally recommended re-assessment with physician signature and rehab treatment order shall be submitted.
- If the patient has additional visits left on the TAR but the date has expired, an date extension will be processed.
- If a patient is discharged from the facility and readmitted, a new TAR shall be submitted. This is the case regardless of remaining visits on the original TAR. Notation that the patient was discharged and readmitted shall be made in the comments section of the TAR.

**ATTACHMENT:**

None

**REFERENCE:**

None

Most Recent Review: 2020/5/18 20/04/24

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Original Adoption: 20/04/24