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Activities

Purpose

It is the policy of the Idaho State Veterans Homes to provide an organized activity program. The activity program is a composite of a variety of processes and services designed to stimulate train and promote residents to achieve greater self-sufficiency. The program provides social, educational, and physical experiences to support the individual in making adjustment to or reversing handicaps or disabilities.

Activity Plans

An activity program shall be developed for each and every resident, according to his or her specific needs and interests. All residents shall be encouraged and assisted to be involved, at whatever level is appropriate for the resident. Individual programming shall include one or more of the following: group activities, special events, outings, 1:1 visits, sensory stimulation, and individual activities.

The completed activity plan is discussed with the Recreation Assistant and Nursing Supervisor on the unit and plans are made for its implementation. It is then filed in that nursing care resident's chart under the care plan section.

Each resident has the right to refuse participation in an activity. If a resident refuses to participate, the Recreation Assistant shall document the refusal, the attempts made to encourage the resident, and the alternate means employed to keep the resident active physically, mentally and socially.

ISVH-Boise will have a written program designed to meet the findings of the comprehensive assessment, individual interest, and the physical, mental and psycho-social well-being of each resident. Each resident's program will be driven by a comprehensive assessment, which takes into consideration: individual interests, physical condition, mental and psychosocial well-being.

In compliance with the MDS guidelines, upon admit, each resident will be observed for an assessment period determined by the MDS Coordinator prior to the completion of the activity portion of the MDS (section F 0300- F0800). The MDS and CAA's will be completed by the due date assigned by the MDS Coordinator. An activity care plan will be developed by day 21. (F279)

An initial activities interest interview and assessment will be completed prior to the completion of MDS Section F0300-F0800.

The Activity Coordinator is responsible to see that the initial activity interview and assessment are completed, the MDS is completed, and the care plan is developed, within the prescribed periods of time.

A resident's attending physician shall approve and sign the resident's care plan which includes the activity care plan indicating it is not in conflict with his overall plan of care. An activities progress note will be completed in conjunction with the 30-day resident review.

Each resident's care plan may be reviewed at least quarterly, upon a change of condition, and annually. Summaries may be written with no less than a quarterly summary, change of condition summary, and annual MDS. The Activity Coordinator is responsible to see that summaries are completed.

Monthly activity participation records shall be kept allowing an accurate recapture of the month's participation, when writing a summary. The Recreation Assistant shall keep the monthly activity participation record current. Each record shall be completed by the 10th of the next month and sent to the Activity Coordinator for review. The sheets will then be filed by unit in the Activity Coordinator's office. Participation records will be kept for a calendar year.

Scheduling of Activities

Monthly Activity Calendars shall be developed under the direction of the Activity Coordinator. The calendar shall reflect planned group activities, be posted, and be large enough for the vision impaired.

The Activity Staff meets monthly and plans the activities for the monthly calendars. The Recreation Assistants design special activities for each level of participation, both group and individual. These schedules are developed prior to the last week of the month for the following month's calendar. In addition to the major activity calendar, an individual unit calendar is prepared and maintained on the individual units. The calendar boards on each floor are prepared by Volunteer Services and are posted a week in advance in order to allow for the posting of changes.

Activity Types:

Spectator group activity, such as attending an athletic contest or a movie, where members of the group are passively involved, not actively participating.

Performing group activity, such as dancing or singing, where people are performing for them or for others.

Independent – Interdependent group activity, such as making decorations for a special event program, where the total project is dependent on each group participant making the same item or performing the same task as all other members of the group.

Interdependent group activity, such as creating a scrapbook where the completion and success of the project is dependent on each participant completing a separate and distinct part of the total project.

Procedures for Group Activities

Scheduling of rooms, equipment, etc., is done in advance. Decisions are made during the activity staff meetings as to which staff member will act as coordinator and be present at each activity. That individual is also responsible for completion of the activity sheet. At times, it may not be necessary for the Activity Coordinator to stay for the entire activity, i.e., evening guest entertainment. Volunteers can be utilized to monitor the activity with the more independent residents.

Birthdays

It is our goal to recognize and honor each resident's birthday and make that day a special occasion.

Recognition of a resident's birthday may include, but is not limited to:

1. A birthday greeting on the resident's door
2. A balloon bouquet
3. Individual birthday cake
4. Singing "Happy Birthday" in the dining room or group setting

Families and organizations are encouraged to participate in the celebration of resident birthdays through gatherings and special activities.

The Recreation Assistants shall be responsible for coordinating birthday recognition details.

Lists of upcoming birthdays are given to the American Legion Auxiliary (ALA), who prepare birthday cards, and provide Canteen Coupons for every resident on their birthday. A list is also given to the Volunteer Coordinator who purchases the cakes with funds provided by the Ladies Auxiliary to the Fleet Reserve Association. These cakes will be purchased the morning of the birthday for birthdays during the regular work week and on Friday for those birthdays occurring on the weekend. All cakes will be placed in the Activity Kitchen, and the Recreation Assistant will make arrangements to see that the cake is delivered to the resident in a timely manner.

The birthday list is finalized and mailed to the ALA representative with the Activity Calendar each month. It is maintained on the Activity/Volunteer Services Administrative Assistant's computer.

Birthday cards for residents are received from a variety of sources. All are given to the Recreation Assistants for delivery to veterans.

1. Cards are received from the ALA.
2. Cards are received for those participating in the Adopt-A-Vet Program.
3. Cards are received from the White House for those veterans over 80 years of age (See "White House Greetings") and are prepared by the ALA volunteer.

4. If cards are received for a resident who has been discharged, consult with Volunteer Coordinator for proper processing.

Birthday parties are organized and directed by Recreation Assistants or other nursing staff.

Individual Activities

One-to-one activities are scheduled as frequently as possible according to the individual's activity plan. Each resident should have special individual activities at least once a month. The Recreation Assistant should schedule these activities between scheduled group activities. These activities may include volunteers visiting with veterans on a one-to-one basis. Examples of individual activities include, but are not limited to:

1. Visit about current events
2. Reminisce about the past
3. Visit about family
4. Give edible treat
5. Bring in Homemade Goodie
6. Take outside on porch
7. Take outside for a walk
8. Help resident write correspondence
9. Read letter or card to resident
10. Validation – listen to resident's concerns and feelings
11. Help resident select television or radio station
12. Hand or back rub
13. Family in to visit
14. Fun and Games (ball toss, blow bubbles, puzzles, trivia, etc.)
15. Movie

Purchasing/Budget

Requests for purchases will be made to the Activity Coordinator for approval. They will then go to the Volunteer Coordinator for approval through IVAL's activity fund.

Progress Notes

Monthly charting, i.e., summaries, quarterlies, annuals, etc., 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 so that a new plan may be developed. A record of each resident's participation, as well as reasons for their nonparticipation, is documented and their recreational therapy goals addressed.

Revised 02/07, 10/10, 01/14, 10/15

Outing Protocol

It is our goal to ensure the safety of our residents and assure a pleasurable experience.

The Activity Coordinator is responsible to see that all details are coordinated, and that staff and volunteers are adequately trained prior to the event.

ISVH-B Activity outings are alcohol free. Exceptions may only be made by coordination between AC, RNM, MSW and resident's MD.

BEFORE:

1. Identify outing to be conducted
2. Identify residents to participate; invite family members as appropriate
 - a. identify residents wishing to attend
 - b. Review limitations with nursing, dietary, and social services, as needed (i.e. coordinating manual w/c for residents who use an EMD. EMD's are not taken on facility sponsored outings.
3. Arrange transportation through the maintenance department
 - a. assure that all volunteers/staff are in serviced in safety techniques
4. Coordinate escorts, including staff and volunteers
5. Identify and gather needed equipment and resources, i.e.:
 - a. Cellular phone
 - b. sunscreen
 - c. Personal care items (clothing change, gloves, wipes, etc.)
 - d. Fluids/snacks (cups, napkins, etc.)
 - e. Oxygen, disposables

DURING:

1. Assure personal care and safety by:
 - a. Maintaining consistent monitoring of resident whereabouts at all times
 - 1.buddy system
 - 2.resident and escort roll call
 - b. Provide regular hydration and snacks
 - c. Assure resident comfort according to climate, i.e.: sunscreen, shade, hats, lap robes, jackets, etc.
 - d. Provide toileting, re-positioning, and personal cares, as needed
 - e. Ensure that medications are dispensed appropriately and as prescribed by qualified personnel on day long outings, i.e., Twin Falls Fishing Trip.
2. Prior to departure from activity, all residents shall be accounted for and personal needs shall be addressed.
3. Residents shall be transported back to the Veterans Home

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AFTER:

1. All residents shall be returned to the nurses' station of their residence and assessed for hydration and personal needs
2. All supplies and equipment shall be returned to their appropriate storage area; soiled items placed in the appropriate location

Protocol for Wandering/Lost Resident during an outing:

Every effort will be made to provide sufficient supervision so as to avoid a resident wandering away or becoming lost. In the event that a resident does wander or become separated from the group, the following measures shall be taken:

1. The activity leader will assure that all other residents on the outing are secure and supervised and immediately notify the Home Administrator.
2. An immediate search shall be initiated by the activity leader, assuring that the other residents remain secure and supervised.
3. If help is required, additional staff shall be dispatched with photo(s), under the direction of the Home Administrator.
4. If the on-site staff cannot locate the resident within 30 minutes, the Home Administrator will make the determination of whether or not to involve local authorities.
5. Once the resident is located, the activity leader will call the Home Administrator so that the search may be terminated.
6. Upon return to the facility, the resident shall be assessed by nursing staff. An incident report shall be filed.
7. A wrap-up, problem-solving session shall be completed within 72 hours, under the direction of the Home Administrator.

Protocol for resident injury during a facility sponsored outing.

See procedure for Resident Incident/Accident When out of the Facility.

Vehicle Communication Procedure

Vehicle usage is coordinated through Maintenance, other than both "Ride with Pride" buses, which is through the Activity Department. Vehicle requests should be made in advance.

Dress Code while on Activity Outings

Paid employees assigned to an activity should check with the Recreation Assistant for proper attire. At all times, attire will be neat, clean and appropriate, as you are representing our facility to the public.

Dress Code for Specialty Days during the Calendar Year

On designated days during the year, the Activity Department will request that staff participate by wearing appropriate attire as specified. This is done for two reasons:

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1. To develop a respite for our residents from the day-to-day task-oriented routine. 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 staff will be neat, clean and appropriately attired.

Pet Therapy Protocol

Pet visits/therapy are designed to provide social and sensory stimulating interactions on a 1:1 or group basis. Because many of the residents were once responsible pet owners and because many have a natural affinity with members of the animal kingdom, pet visits/therapy will be provided on an on-going basis.

Pet therapy is defined as interaction with residents by a qualified therapist and an accompanying trained animal. All other animal visits are defined as “visits”.

The Activity Coordinator shall supervise the pet visits/therapy program.

1. All pet visits/therapy shall be coordinated through the Activity Coordinator
2. Volunteers shall be oriented to include:
 - a. proof of vaccination/health records
 - b. relief area or clean-up, as needed
 - c. notifying nursing staff of presence
 - d. becoming aware of specific resident needs through staff
 - e. approaches to residents
 - f. areas where visits may be conducted
3. All animals shall be kept on a leash, in hand, in arms, or in a cage at all times
4. All visits shall be documented on a resident activity worksheet and recorded by activity staff on activity participation records.
5. Dog visits to the Special Care Unit (SCU) are to occur only with the coordination of the SCU Activity Aide. The SCU Activity Aide is to be present during the visit/activity.

Family pet visits are encouraged, as appropriate, and as tolerated by the resident.

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ACRONYMS AND ABBREVIATIONS

1E	One East	CABG	Coronary artery bypass graft
2E	Two East	CAD	Coronary Artery Disease
1W	One West	Cath	Catheter
2W	Two West	CBC	Complete blood count
&	And, and	cc	Cubic centimeter
A1C, HbA1C	Hemoglobin A1C	CHF	Congestive Heart Failure
AAA	Abdominal aortic aneurysm	cm	Centimeter
A/O	Alert and oriented	CMP	Comprehensive Metabolic Panel
AC, ac	before meals	CNA	Certified Nursing Assistant
ABD, abd	Abdomen	CNS	Central Nervous System
ABX, abx	Antibiotics	C/O, c/o	complaint of
ADA	American Diabetic Association	CO2	Carbon dioxide
ADL	Activities of daily living	COPD	Chronic Obstructive Pulmonary Disease
Ad lib	As desired, if the patient so desired	COTA	Certified Occupational Therapy Asst.
Adm.	Administration	CPR	Cardio pulmonary resuscitation
AEB	As Evidenced By	CP	Care Plan
AFIB	Atrial fibrillation	CRF	Chronic Renal Failure
AKA	Above the knee amputation	CRP	C-reactive protein
ASA	Aspirin	CS	Central Supply
AM	Morning	CVA	Cerebral Vascular Accident or stroke
Amb, amb	Ambulation	CXR	Chest x-ray
Amt, amt	Amount	DC, dc	Discharge or discontinue
@	About	del	delete
Assmnt.	Assessment	DHW	Department of Health and Welfare
B&B	Bowel & Bladder	DJD	Degenerative Joint Disease
BG	Blood glucose	DM	Diabetes Mellitus
BP, B/P	Blood pressure	DNI	Do not intubate
BID, bid	Twice a day	DNR	Do not resuscitate
Bilat, bilat	Bilateral	DNS	Director of Nursing Services
BLE	Bilateral Lower Extremities	DOB	Date of birth
BM	Bowel Movement	drsg.	Dressing
BMI	Body Mass Index	Dr., Dr	Doctor
BMP	Basic metabolic panel (Chem 12)	DVT	Deep Vein Thrombosis
BPH	Benign prostate hypertrophy	DX	Diagnosis
BR	Bed rest	ECG, EKG	Electrocardiogram
BRP	Bathroom privileges	ED	Emergency Department
BS	Bowel Sounds	EEG	Electroencephalogram
BSC	Bedside Commode	EOB	Edge of Bed
BSU	Bedside Unit	eMAR	Electronic Medication Administration Record
BUE	Bilateral Upper Extremities	ESR	Erythrocyte Sedimentation Rate
BUN	Blood urea nitrogen	ESRD	End-stage Renal Disease
BVH	Boise Veterans Home	eTAR	Electronic Treatment Administration Record
°C	Celsius degree	ETOH	Alcohol
C-Diff	Clostridium Difficile	ER	Emergency Room
C&S	Culture and Sensitivity	Etc, etc	etcetera
CA	Cancer	F	Female
CAA	Care Area Assessment	°F	Fahrenheit degree

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FSBG	Finger stick blood glucose	MRSA	Methicillin-Resistant Staphylococcus Aureus
F/U, f/u	Follow up	MV	Multivitamin
FX	Fracture	MVA	Motor vehicle accident
gal	Gallon	MVI	Multivitamin with Iron
GERD	Gastroesophageal Reflux Disease	NAR	Nutrition at Risk
GI	Gastrointestinal	NG, N/G	Nasogastric
H2O	Water	NIDDM	Non-Insulin Dependent Diabetes Mellitus
HCT	Hematocrit	NKDA	No Known Drug Allergies
HGB	Hemoglobin	noc	At night
HOB	Head of bed	NP	Nurse Practitioner
HS	Hour of sleep	NPM	Nursing Procedure Manual
HT, Ht, ht	height	NPO	Nothing by mouth
HTN	Hypertension	NSAID	Non-steroidal antinflammatory drug
HR, hr	hour	NSU	Nonsecure unit
HX	History	O2	Oxygen
I	Independent	OJ	Orange juice
ICU	Intensive care unit	OOB	Out of bed
IDDM	Insulin Dependent Diabetes Mellitus	OT	Occupational Therapy
IDT	Interdisciplinary Team	oz	ounce
IM	Intramuscularly	P or p	pulse
I&O	Intake and output	PA	Physician's Assistant
Irr.	Irregular	pc	After meals
Isol.	Isolation	PCC	Point Click Care
ISVH	Idaho State Veterans Home	PE	Pulmonary embolism
ISVH-B	Idaho State Veterans Home - Boise	PERL	Pupils equal and reactive to light
IV	Intravenously	PERLA	Pupils equal and reactive to light and accommodation
Ltr.	Liter	PM	afternoon
KCL	Potassium	PNA	Pneumonia
L), L.	Left	PO, po	By mouth
Lab	Laboratory	POC	Point of Care
lb, lbs	Pound, Pounds	PPD	Purified Protein Derivative
LFT	Liver function tests	prep	prepare
LLE	Left Lower extremity	PRN	As needed
LLQ	Left Lower quadrant	PSA	Prostate Specific Antigen
LPN	Licensed Practical Nurse	PT	Physical Therapy
LS	Lung Sounds	PT/INR	Prothrombin time & International Normalized Ratio
LUE	Left Upper Extremity	Q , q	Every
LUQ	Left Upper Quadrant	QAM, qam	Every morning
M	Male	QD , qd	Every day
MCNA	Medication Certified Nursing Assistant	QHS, qhs	Every night or at bedtime
MD	Medical Doctor	QID, qid	Four times a day
MDS	Minimum Data Set	QOD, qod	Every other day
med	Medicine	QS, qs	Every shift
mEq	milliequivalents	qt	Quart
mg	milligram	R), R.	Right
MI	Myocardial Infarction	R, r	Respirations
min	Minute	RA	Room Air
ml	milliliter	R.A.	Rheumatoid Arthritis
mm	millimeter	RBC	Red blood cell
MRI	Magnetic resonance imaging	RD	Registered Dietician

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Rec. Asst	Recreation Assistant	VA	Veteran's Administration
Rehab.	Rehabilitation	VS	Vital Signs
Res, res	Resident	w/	With
RLE	Right Lower Extremity	w/c	Wheel chair
RLQ	Right Lower Quadrant	w/o	Without
RN	Registered Nurse	WBC	White blood cell
RNA	Restorative Nursing Assistant	WNL	Within normal limits
RNM	Registered Nurse Manager	Wt	Weight
ROM	Range of Motion		
R/T, RT	Related To		
RUE	Right Upper Extremity		
RUQ	Right Upper Quadrant		
Rx	Prescription		
S/E	Side effects		
SO	Standing Order		
SOB	Shortness of breath		
SCNA	Senior Certified Nursing Assistant		
SCU	Special Care Unit		
SL	Sublingual		
S/S, s/s	Signs and symptoms		
SR	Side rails		
ST	Speech Therapist		
stat	At once, immediately		
SW	Social Worker		
T3	Triiodothyronine		
T4	Thyroxine		
T, t	Temperature		
TB	Tuberculosis		
Temp	Temperature		
TIA	Transient Ischemic Attack		
TID	Three times a day		
TO	Telephone Order		
TSH	Thyroid stimulating hormone		
TX	Treatment		
UA	Urinalysis		
URI	Upper respiratory infection		
UTI	Urinary tract infection		

03/2014, 11/14, 07/18

24-HOUR CHART/MEDICATION CHECKS

1. Licensed nursing staff (NOC) shift shall nightly review physician orders for each resident to ensure order has been completely and accurately processed.
2. In conjunction with the chart checks, licensed nursing staff (NOC shift) shall remove/ensure removal of all discontinued medications, per chart review. This is done by pulling a discontinued medication report from PCC.
3. In conjunction with the chart checks, licensed nursing staff (NOC shift) shall remove/ensure removal of all medications where the dosage was changed – increase or decrease.
4. Discontinued/dosage changed medications shall be placed in the med room for pharmacy pick- up.
5. Discontinued/dosage changed narcotic medications shall remain in the locked box in the medication cart until pharmacy is notified for pick-up/disposal.
6. In addition, the licensed nurse will review each new order to ensure that the care plan was updated, if applicable, and update/refer to RN Manager, as appropriate.

3/04, revised 08/07, 11/08, 11/14, reviewed 04/16

ALERT CHARTING

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

1. Alert Charting will be implemented when one or more of the following resident situation/ conditions occurs:
 - a. Medication errors which have the potential to cause harm, e.g. wrong dose, wrong resident.
 - b. A new acute clinical condition such as UTI, respiratory infection, skin conditions such as shingles, rashes, cellulitis and/or an increase in behaviors or change in LOC.
 - c. Incident of a significant nature, such as a fall with or without injury, choking, or a Resident to Resident altercation.
 - d. Admission/Readmission of a Resident.
2. The first nurse noting the condition shall be responsible for initiating the Alert charting order, entering the appropriate information in the Alert Charting Book, completing the Incident Report if appropriate and notifying the MD and Family.
3. Initiate an Alert Charting order in PCC. Use Alert Charting template and in the indications box write in the specific reason/problem that Alert Charting was implemented. (UTI, URI, etc.)
4. Staff member responsible for implementing Alert Charting will enter the Resident's name in the Alert Charting book located at each of the nurses' stations. Items to be completed include:
 - a. Start date.
 - b. Reason/Problem (e.g. URI, UTI, shingles, increased behaviors)
 - c. Items requiring documentation/assessment. (e.g. “s/s of adverse reactions” “lung sounds” “sputum color, odorous, quantity, consistency,” assessment of source of pain, skin tear, etc.)
 - d. Nurse. (initial)
 - e. Ending date. (This date is determined at the onset of Alert Charting- typically Alert Charting continues for a period of 72 hours on a new acute illness, diagnosis or fall, medication change, incident, or change of condition.) (Serious or on-going issues may extend the alert charting period.)
5. Alert Charting shall be done q shift by the licensed staff assigned to the resident, according to the documentation items required.

Revised 10/03, 07/04, 04/06, 10/08, 05/09, 03/17

CARE PLAN DEVELOPMENT

The Interdisciplinary team will develop and implement a baseline and/or comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of admission.

Explanation and Compliance Guidelines:

1. The care plan will:
 - a. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
 - i. Initial goals based on admission orders
 - ii. Physician orders
 - iii. Dietary orders\Therapy services
 - iv. Social services
 - v. PASARR recommendation, if applicable
 - vi. Discharge plan.
2. The interdisciplinary team shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.
 - a. Once gathered, initial goals will be established that reflect the resident’s stated goals and objectives.
 - b. Interventions shall be initiated that address the resident’s current needs including:
 - i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.
 - ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.
 - iii. Any special needs such as for IV therapy, dialysis, or wound care.
 - c. Once established, goals and interventions shall be documented in Point Click Care.
3. The MDS nurse shall verify within 48 hours that a care plan has been developed.
4. A printed copy of the care plan will be provided to the Resident and/or representative in a language that the resident/representative can understand.
 - a. Along with the care plan, a list of current medications and treatment list shall be provided
 - b. Items to be reviewed with resident and family shall include but is not limited to the POST, Advance Directives, current labs, discharge goals or plan.
5. In the event that the comprehensive assessment and care plan identified a change in the resident’s goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the care plan, those changes shall be incorporated into an updated care plan provided to the resident and his or her representative, if applicable.

Revised 11/08, Reviewed 05/14, Revised 11/17, 08/18

CARE PLAN ACKNOWLEDGEMENT – RESIDENT/REPRESENTATIVE

My signature below specifies that I have:

1. Discussed
2. Viewed my plan of care and was given the opportunity to ask questions and state my preferences in my care and goals of care.

Items reviewed and/or provided:

- Baseline care plan
- Comprehensive care plan
- POST/Advanced Directives/Mortuary
- Current medication list
- Current treatment list
- Current labs
- Current discharge goals or plans

Signatures:

Resident: _____ Representative:

Licensed Nurse: _____ Social Services:

C.N.A. _____ Activities:

Restorative: _____ Rehab:

Others: _____ Others:

Date:

Resident Name:	Room #:	Medical Records #:
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11/17

CARE PLANS, TEMPORARY

Temporary care plans will be utilized when there is a change in the resident's status (problem) and temporary interventions (approaches) must be put into place to achieve desired results (goals).

Temporary care plans are put into place for a variety of situations such as a new medication, a fall, a wound, a urinary tract infection, an upper respiratory infection, etc.

1. The temporary care plan will be a pre-formatted care plan with a stated problem(s), goal(s), and suggested interventions located in PCC in the Boise Care Plan Library.
2. The licensed nurse identifying the new/temporary problem is responsible for instituting the care plan.
3. Steps for completing this process include:
 - a. Identifying the problem.
 - b. Select the appropriate care plan in the Boise Care Plan Library located in PCC.
 - c. Selecting those items that specifically apply to the resident's problem and completing the remainder of the information required by each care plan.
 - d. Identifying additional interventions that are appropriate for the situation and adding them to the temporary care plan.
 - e. Reviewing the resident's comprehensive care plan to ensure that there is not a conflict with existing problem(s)/goal(s)/interventions.
 - f. Resolving any discrepancies between the two care plans. Typically, these discrepancies are brought to the attention of the RN Unit Manager for resolution.
4. Once the problem is resolved, the temporary care plan will be resolved in PCC or entered "permanently" into the resident's comprehensive care plan if the problem has been determined to be long-standing.

Revised 6/06, 05/14

CREDENTIALING AND PRIVILEGING

Credentialing

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

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 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, and 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 OIG 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

The following core criteria shall be maintained on each provider:

1. 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).
 - a. The license must be current.
 - b. The license should be unrestricted. Any restriction must not interfere with the provider's ability to perform within the scope of their license.
2. A Licensure History or Self-Attestation should be completed. (See applicable forms.)
3. Current certification, if applicable.
4. Relevant education, training, and experience.
5. Current competencies.
6. 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."

The following core criteria shall be maintained on each contract agency that provides care to residents and for those providers who provide coverage (“call”) in the absence of the resident’s primary physician:

1. The State Home Administrator shall request that a letter be written, on official letterhead of the agency, to the Medical Director of the State Home to document the requirements.
2. The letter must include:
 - a. A list of all clinicians to be practicing in the State Home.
 - b. The period (from and to) for which they are current for licensure, education, training, experience and competency.
 - c. A statement that the person and/or persons named do not have a physical or mental health condition that would adversely affect the applicant’s ability to carry out the clinical duties requested from the facility and are known to be clinically competent to practice the full scope of practice/privileges granted at the home, to satisfactorily discharge the applicant’s professional and ethical obligations, as attested to by (name and telephone number of highest- level person in that organization’s credentialing center).

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 credential file.

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.
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.
4. Each current privileged provider will be reviewed and undergo the Credentialing and Privileging process no less than every two years.

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

Revised 07/04, 6/12, 3/13

LICENSED NURSE CREDENTIALING AND LICENSE VERIFICATION

Policy:

It is the policy of this facility that all licensed nurses (RN/LPN's) have their credentials and license verified upon initial employment and biannually thereafter during the term of employment.

Policy Explanation and Compliance Guidelines:

1. Credentials and license are evaluated as a part of the annual performance appraisal process for each licensed nurse.
2. The Administrative Assistant for the Administrator will provide the licensed nurse with a notice of his/her license expiration date. The Director of Nursing Service will be provided with a copy of such notice.
3. Licensed nurses employed by this facility have their credentials and license verified during the initial employment process through the Human Resource office.
4. Reverification of license is required at the intervals set by the Board of Nursing of this State. Licensed nurses are required to renew their license prior to the expiration of their license.
5. If the licensed nurse has not renewed prior to his/her license's expiration date, the nurse may not work past midnight of the expiration date of his/her current license. The facility may place the nurse on unpaid administrative leave until appropriate licensing information has been provided or may terminate employment.
6. Licensed nurses not employed by our facility but who may perform services at our facility are credentialed through the agency in which they represent (e.g. home health, hospice, etc.). Agencies are required to provide licensing information upon request from the Administrator, or his/her designee.
7. The following documentation (as applicable) is required for the credentialing and licensing process:
 - a. Evidence of a current, unencumbered RN/LPN license to practice in this State.
 - b. Current CPR Certification
 - c. Other as may be requested by the facility to verify credentialing and licensing status.
8. Background checks and verification of employment status will be conducted in accordance with our facility's established policies and procedures governing these issues.
9. Inquiries concerning this policy should be directed to the Administrator or to the Director of Nursing Services.

08/18

NURSING SERVICES AND SUFFICIENT STAFF

Procedure:

It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.

Procedure Explanation and Compliance Guidelines:

1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.
2. The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
3. The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care.
4. Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.
5. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
6. The facility must use the services of a registered nurse for at least 24 consecutive hours a day, 7 days a week.

08/18

PROCEDURES FOR STAFF 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 09/08; Reviewed 11/13

PROCEDURE FOR HANDLING EXCESSIVE USE OR SUSPECTED ABUSE OF SICK TIME

The RN Unit Managers in consultation with the staffing coordinator 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 unit manager 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 11/13

CALL-IN PROCEDURE

1. Each staff member will personally notify the facility of an absence at least two (2) hours prior to the beginning of their scheduled shift. (Calls from family members, etc. will not be accepted unless the employee is incapacitated.)
2. When a call-in is received, the person taking the call will document the information on the Staff Call-In Tracking form.
3. This form will be attached to the Daily Assignment sheet where the RN Unit Manager or licensed nurse will document the call-in on the unit schedule and as necessary, cover the shift.
4. The Staff Call-In Tracking form will then be routed to the Staffing Coordinator for documenting the absence on the master schedule.

Revised 08/02, 09/09, Reviewed 11/13, Revised 08/18

EMPLOYEE SIGN-IN SHEETS

The employee sign-in sheets are used to accurately track nursing staff employee schedule and work time and to calculate daily patient care nursing hours.

1. Nursing staff employees shall sign in on the Daily Staffing Worksheet for the unit assigned. (This sheet is posted on each of the nursing units.)
 - a. Employee shall indicate the actual time started work.
 - b. Employee shall indicate the actual time ended work.
 - c. Employee shall total actual work time for each shift, each unit.
2. If an employee floats to another unit, he/she shall sign out and sign in, etc., as appropriate on each unit worked.
3. The licensed nurse on each unit, each shift shall:
 - a. Ensure staff assigned to the unit has signed in.
 - b. Ensure staff adheres to established 8-hour work schedule, unless pre-approved for extended work schedule. Information to support/approve extended work schedule shall be written on the back of the sign-in sheet and signed by the licensed nurse.
 - c. Ensure the unit's resident census at the beginning of each shift is indicated on the sign-in sheet.
4. Unit RN Manager (or designee) shall review Daily Staffing Worksheet for completeness, accuracy, adherence to facility staffing policies, procedures, and practices; then forward to the Staffing Coordinator.
5. The Staffing Coordinator shall tabulate the worksheet as directed.

Start and end times should reflect the actual time employee was engaged in work.

12/99, revised 02/03, 04/06, Reviewed 11/13

FILLING A CALL-IN VACANCY

The following procedure will be followed when filling a nursing staff vacancy.

1. Employee taking call-in shall complete a Staff Call-In Tracking sheet, attach it to the staffing sign-in sheet and make the necessary changes on the sign-in sheet.
2. Licensed nurse taking call-in shall notify the RN Unit Manager and/or the Staffing Coordinator of the expected vacancy if the call-in occurs during regular business hours.

After hours and on weekends, the licensed nurse shall utilize the following to fill the vacancy:

1. Check the staffing sign-in sheet and call the other units to determine if there are "extra" staff available to float to the unit in need.
2. Contact staff currently on a shift to determine if anyone is willing to fill the vacancy.
3. Contact staff scheduled to work a shift prior or shift following expected vacancy to determine if willing to come in early or stay over.
4. Contact employee(s) who are scheduled off.
5. Utilize the PRN list.
6. Contact RN Unit Manager/DNS for further instructions if unable to cover a shift utilizing the above.
7. Once the above process has been completed, contract agency staff may be utilized following approval by the Administrator, DNS, or RN Unit Manager.

Revised 07/02, 03/12, Reviewed 11/13

TRAINING REQUIREMENTS

Policy

It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.

Policy Explanation and Compliance Guidelines:

1. Each nursing department employee will be required to attend 24 hours of in-service training per calendar year.
2. The amount and types of training necessary will be based on a facility assessment.
3. Training will include, at a minimum:
 - a. Effective communication for direct care staff.
 - b. The rights of the residents and the responsibilities of the facility to properly care for its residents.
 - c. Elements and goals of the facility's QAPI program.
 - d. Written standards, policies, and procedure for the facility's infection prevention and control program.
 - e. Written standards, policies, and procedures for the facility's compliance and ethics program.
 - f. Behavioral health training.
 - g. Dementia management and care of the cognitively impaired.
 - h. Abuse, neglect, and exploitation prevention.
 - i. Safety and emergency procedures.
 - j. Identification of changes in condition.
 - k. Cultural Competency
4. In-service training will be provided by qualified personnel in a variety of formats.
5. The responsible department will maintain a training schedule and documentation system for completed training of the required individuals.
6. Documentation of required training will be forwarded to the medical records department to be placed into the Education and Training record binders.
7. It is the responsibility of each employee, volunteer, or contract staff to complete required training.
 - a. The facility will post in advance a notice stating the time, topic and date of the in-service.
 - b. The facility will offer a variety of training methods and times to accommodate individuals.
 - c. Off duty employees will be encouraged to attend in-services, although attendance is not mandatory.

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- d. If the notice is marked "MANDATORY," then attendance is required. Any employee not able to attend a "MANDATORY" in-service must provide an explanation to their manager and attend a make-up session.

Revised 04/06, 11/13, 08/17, 08/18

IN-SERVICE HOURS

1. Staff members are responsible for entering their names legibly on all in-service sign-in sheets or by initialing by their printed name on the in-service sign-in sheets in order to get credit for the in- service.
2. The Health Information Manager is responsible for tracking of all in-service hours.
3. After each in-service, the presenter is responsible for getting the completed sign-in sheet to the Health Information Manager.
4. At the end of each calendar year and as needed, the number of in-service hours each employee has earned will be determined. Employees who were hired during the year are expected to obtain a total of at least 2 hours of training per month worked.
5. The RN Unit Managers will be responsible for ensuring that nursing employees have accumulated their mandatory 24 hours of in-services for the year. If the employee has not received 24 hours of in-service credit, the RN Unit Manager 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.
 - a. Date of class
 - b. Topic
 - c. Number of classroom hours
 - d. Evidence of attendance
7. Employees who complete self-study training must provide a self-directed in-service sheet to the Staff Development Coordinator.

Revised 02/03, 10/03, 01/07, 11/13, 08/17

LABORATORY TEST RESULTS NOTIFICATION

Purpose

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

Procedure

1. Critical Lab Values:
 - a. The laboratory contract provider will call the facility with any critical lab values.
 - b. Upon receipt of information regarding critical lab values, the licensed nurse will immediately contact the resident's physician/medical provider for further instructions/orders.
2. Abnormal Lab Values:
 - a. The laboratory contract provider will indicate abnormal laboratory results on the hard copy.
 - b. Upon receipt of the hard copy, the unit clerk will stamp the copy and present to the licensed nurse assigned to the specific resident.
 - c. The licensed nurse will review, initial as reviewed, and call the physician/medical provider if necessary, of the results to obtain further instructions/orders.
3. Normal Lab Values:
 - a. Upon receipt of the hard copy revealing normal lab values, the unit clerk will stamp the copy and present to the licensed nurse assigned to the specific resident.
 - b. After appropriate reviews and signatures, the hard copy will be scanned into the resident's medical record.

11/00, revised 02/03, 04/13, 08/17

LIGHT DUTY – NURSING STAFF

If a nursing staff member has a physical limitation resulting from a work-related injury:

- The Staff Development Coordinator will be responsible for determining appropriate work assignment(s)/schedule for a nursing employee with physical work limitation(s). In his/her absence, the RN Unit Manager on the affected unit will determine the work assignment(s).
- Work assignments will be based on medically documented restrictions, staffing needs of the facility, and the employee's regularly scheduled shift.

The staffing pattern for certified nursing assistants restricted to light duty will be based on facility needs in a manner that promotes resident's physical, mental and psychosocial well-being.

12/99, Revised 05/01, 02/03, Reviewed 11/13

MOTION DETECTION DEVICE IDENTIFICATION

Purpose

To ensure easy identification of chair, bed, and tag alarms (or other motion detection devices) used to reduce or eliminate the potential for resident falls.

Procedure

Once a motion detection device has been identified as having the potential to reduce or eliminate a resident's potential to fall, the following procedures will be implemented:

1. Care plan will be developed to describe the type of motion device used, where, and when.
2. Kardex and Zone Work Sheet revised to reflect the motion detection device implemented.
3. Staff in-serviced regarding the specific residents using motion detection devices and the need to ensure all are in working order (e.g., batteries charged/changed, device turned on).
4. The Unit RN Manager is responsible for ensuring compliance with the above procedure and for monitoring activities related to the use of the motion detection devices.

10/00, revised 04/05, 09/05, 10/10, 12/15

MOTION DETECTION ALARM SYSTEM

Purpose

To ensure motion detection devices such as wheelchair, bed pressure alarms and tag alarms are maintained in good working order.

Procedure

1. In consultation with nursing staff, the facility's storekeeper shall be responsible for ensuring motion detection devices, including wheelchair and bed pressure alarms, tag alarms and other similar devices are available as the need arises.
2. Each motion detection device or pressure pad is to be replaced as needed. Follow the setup, testing, maintenance and troubleshooting instructions provided with each device to determine if pad needs to be replaced.
3. Sensor pads with change pad indicator automatically alerts caregivers when sensor pad is expired. When the sensor pad has expired, the change pad indicator monitor will emit a continuous chirping sound and the "check pad" light on the monitor will illuminate. Replace the sensor pad immediately.
4. Each nursing unit shall maintain a list of each resident's motion detection device. These devices will be indicated on the resident's Kardex and Zone Worksheet.
5. The storekeeper shall be responsible for the retrieval of expired pads and their replacement.

11/00, Revised 02/03, 12/15 Reviewed 11/13

NURSING CLOTHING AND UNIFORM PROCEDURES

Uniforms

Uniform components for the nursing staff are:

- Uniform dresses
- Uniform/scrub skirts and blouses
- Solid/print scrub tops/scrub pants

Shoes

Shoes should be comfortable, clean, and in good repair. Open toe sandals are prohibited for safety reasons.

Casual Clothing

Casual clothing may be worn each Friday. For the purposes of this procedure, casual clothing is jeans in good repair worn with inoffensive tee shirts, shirts or sweaters, and/or Idaho Veterans Olympic tee shirts/sweatshirts. No shorts 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.

Grooming

Direct caregivers shall have nails in good repair and a limited amount of ring/hand jewelry.

A uniform must be worn with an identifying nametag. The nametag shall be issued by the Veterans home.

The home's Administrator shall be the final authority on all matters regarding clothing and uniforms.

Revised 09/02, 04/06

OVERTIME

Overtime will be paid to staff members if authorized by supervisory personnel. Overtime is considered any hours worked over forty (40) in a week. Work week is Sunday thru Saturday.

Hands-on caregivers receive overtime at 1 1/2 times the hourly rate. LPNs receive overtime pay at 1 1/2 times the hourly rate which may be paid for or compensatory time accrued.

RNs may receive overtime at 1 1/2 times hourly rate. (DNS is the exception).

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

Revised 11/13

ORDER REVIEWS

Purpose

To ensure accurate physician orders for each resident of the facility.

Procedure

1. Five days prior to the end of each month, the signature page for the order review will be printed by the unit clerks.
2. The unit clerk from each unit will forward the signature page to the pharmacist for drug regimen review.
3. The pharmacist will complete the review and route the signature page back to the unit's RN manager (within three business days).
4. The unit RN manager will review the pharmacist recommendations and make suggestions, as appropriate.
5. The unit RN manager, or his/her licensed nurse designee, will then review the current physician orders and sign the signature page.
6. Deletions and changes to the orders must be made prior to the physician signing the signature page and must be dated and initialed by the person making the changes.
7. Following the review of these items, the forms will be returned to the unit clerk for processing and then will be forwarded to the resident's primary physician for signature.
8. Following the review and signature by the physician, the signature page will be returned to the unit clerk for processing. The signature page will then be forwarded to the Director of Nursing for order review and signature. The Director of Nursing will return the signature page to the appropriate unit so it can be signed by the RN Manager and then scanned into the resident's medical record.

Once the signature page has been signed and dated by the physician no one can alter it.

4/00, revised 5/01, 10/02, 04/12, 11/14, 04/16

ORDER REVIEW FORM

Pharmacy Review:

1. Comments:

2. Dosing safety/recommendations:

I have reviewed the facility's monthly physician orders.

Pharmacist signature: _____ Date: _____

Nursing Review and Comments:

I have reviewed the facility monthly physician orders and the pharmacy review above.

Nurse signature: _____ Date: _____

Physician Review and Comments:

I have reviewed the facility monthly physician orders, the pharmacy review and the nursing comments above.

Physician signature: _____ Date: _____

DNS signature: _____ Date: _____

Orders noted/reviewed by:

Nurse signature _____ Date: _____

RESIDENT SUICIDE ATTEMPTS AND THREATS

Purpose

Resident suicide threats and suicide attempts shall be taken seriously and addressed appropriately.

Procedure for Attempted Suicide

1. Staff will take immediate action as indicated to keep the resident safe while calling for assistance.
2. The resident will not be left alone until transported from the facility.
3. The charge nurse will dial 911 for immediate transfer to the ER.
4. The physician, responsible family member, RNM and DNS must be notified as soon as the situation is stable.
5. The event will be documented in the medical record including all actions taken, VS, physical assessment, notifications and time transferred from the facility.

Procedure for Suicide Threat

1. Staff will report all Resident suicide threats immediately to the Nurse Manager and the unit Social Worker who will immediately assess the situation. A staff member will remain with the resident while the evaluation is being made.
2. After assessing the Resident, the Nurse Manager or Social Worker will notify the Resident's attending Physician, the responsible party, and the Director of Nursing.
3. Based on the multidisciplinary staff assessment, the physician may order an emergency psychiatric evaluation through the hospital emergency room. The facility may provide one-to-one supervision, 15-minute checks, and/or alert law enforcement if the resident is dangerous to others.
4. All nursing personnel and other staff involved in caring for the Resident shall be informed of the suicide threat and be instructed to monitor the resident's mood and behavior and report changes in the Resident's behavior immediately until a physician has determined that a risk of suicide does not appear to be present.
5. Staff will document the event in the medical record including all actions taken, VS, physical assessment and notification

11/16

ELOPEMENT RISK ASSESSMENT

1. A resident upon admission to the ISVH – Boise will have a BVH Elopement Risk Assessment completed by licensed nursing staff in Point Click Care (PCC) Assessments tab.
2. A quarterly BVH Elopement Risk Assessment will be completed thereafter by the Unit RN Manager (or designee). This assessment will coincide with the Resident's RAI schedule; an Elopement Risk Assessment will be completed PRN if a resident demonstrates any verbal or physical attempt to elope from the facility.

The Elopement Risk Assessment is composed of thirteen clinical parameters. These are as follows:

1. Able to ambulate, self-propel wheelchair, etc.
2. Able to move a piece of furniture, a walker, or a wheelchair in order to exit over a barrier (e.g. wall, fence, etc.)
3. Verbalizing desire to leave
4. Aggressiveness/Resistance to care
5. Agitation /Restlessness
6. Exhibits distress due to recent change in schedule of routine/new to unit
7. Misinterpretations of sights and sounds/hallucinating
8. Wandering history
9. Insists on maintaining a pre-admission lifestyle/routine (e.g. daily outdoor walks) and does not exhibit safe decision making, placing the patient at risk for elopement.
10. Prior elopements or attempts
11. Exit seeking
12. Looking for spouse/loved one
13. Cognitive diagnosis such as Alzheimer's disease, dementia, delusions, paranoia, anxiety, depression, etc.

Within 3 days of completion of the assessment the IDT will determine if the resident requires interventions to prevent elopement. Any "yes" response above indicates a risk of elopement and will have a care plan developed which addresses identified risk factors and if a roam alert device is needed. Each of the conditions in this Risk Assessment must be considered in determining the elopement risk for the patient. Patients who are not physically capable of elopement are not considered at risk.

3. One episode of exit seeking by a resident in 8 hours will result in Q15 min checks being implemented, unless they reside on the SCU. If a resident does not reside on the SCU the Elopement Risk Assessment will be completed, and interventions put into place and care planned.

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4. Two or more episodes of exit seeking by a resident will result in a placement of 1:1, unless they reside on the SCU. If a resident does not reside on the SCU the Elopement Risk Assessment will be completed, and interventions will be put into place and care planned.

04/14, revised 09/14, 04/16

WANDERING / ELOPEMENT PROTOCOL

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

1. The licensed nurse will be notified.
2. The licensed nurse or designee will overhead page the Resident.
 - a. To overhead page: Pick up phone and press the PAGE button. Speaking slowly and distinctly (using the resident's full name) three times, on the overhead pager, requesting the resident to come to the nurse's station.
3. The Licensed Nurse will initiate a search of the facility using the Elopement Check List.
4. The Licensed Nurse will call the RN Manager of the unit to report the incident.
5. If the resident has not been located after the above steps have been completed, the licensed nurse on the unit will notify the resident's family, DNS, Maintenance Op. Supervisor, IT department, Home Administrator, Director of Nursing Services, Social Services Director and the Ada County Dispatcher (377-6790).
6. If the resident has not been located after 15 minutes, the IT department will be requested to look at the surveillance system to help locate the missing resident and what they were wearing at the time they left the building. The Administrator or IT will review the footage.
7. The Social Services Director may call the following:

ISVH Call List	All cab/taxi companies	Local bus dispatch
Greyhound bus depot	Community House	Surrounding motels
Rescue Mission and other homeless shelters	Local bars	St. Luke's Hospital
St. Al's Regional Medical Center	VA Medical Center	

The search will continue until law enforcement and the Home Administrator call it off.

When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall:

- a. Examine the resident for injuries;
- b. Notify the Attending Physician;
- c. Notify the resident's legal representative (sponsor) of the incident;
- d. Complete and file Report of Incident/Accident; and
- e. Document the event in the resident's medical record.

02/01, revised 02/03, 04/14, 06/17; Reviewed 04/16

ELOPEMENT CHECK LIST

1. Ensure the resident is not on an activity away from the nursing unit or on leave from the facility:
 1. Activities
 2. Family
 3. On outing
 4. Appointment
2. Institute a thorough search of the entire unit.
 1. Check all resident rooms on both halls to include resident bathrooms
 2. Shower Rooms
 3. Utility and storage rooms
 4. Common areas
 5. Unit balconies
 6. Nursing station
 7. Staff break room
 8. Offices
3. Call all other nursing units and the Dom/Residential care unit and describe the resident. Each unit (1 East, 2 East, 1 West and 2 West) will search their entire unit to include:
 1. Check all resident rooms on both halls to include resident bathrooms
 2. Shower Rooms
 3. Utility and storage rooms
 4. Common areas
 5. Unit balconies
 6. Nursing station
 7. Staff break room
 8. Offices
4. Send a caregiver, on the zone where the resident is missing, to look on the Main floor in all hallways and common areas, including but not limited to:
 1. Dining Room
 2. Lobby/Canteen
 3. Library/Activity Room
 4. All Stair Wells
 5. Kitchen
 6. Therapy Gym
 7. Chapel
 8. Court yards
 9. Smoke Room
 10. Beauty Shop
 11. Business office and other offices
 12. Bathrooms

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5. Two caregivers will be sent to walk around the perimeter of the Idaho State Veterans Home.
6. Seek assistance from the security contractor, M & T Patrol Services 376-6853, available between the hours of 2030 and 0430) to search the VA and grounds.
7. Call the RN Manager of the unit to report the incident.
8. If the resident has not been located after the above steps have been completed the licensed nurse on the unit will notify:
 1. Resident's family
 2. Director of Nursing
 3. Maintenance & Operations Supervisor
 4. IT Department
 5. Home Administrator
 6. Social Services Director
 7. Ada County Dispatch (377-6790)

06/17

WANDERING RESIDENTS' MONITOR SYSTEMS

There are two (2) systems in the facility to assist the staff in ensuring the safety of our wandering residents.

Maglock System

This system is utilized on the 2 West doors leading into the stairway. If the proper code is not entered into the panel located by the doorway, then the door will not open. (Maglock activates).

Roam Alert™ System

This system is installed on thirteen exit doors.

These doors are

1. Main Entrance
2. Canteen exit
3. Door to loading dock
4. Exit door out to annex
5. Back exit leading to the enclosed smoking room
6. Exit Door next to the library
7. Sliding doors to 1 West Smoking Patio
8. West Unit Stairwell exit
9. Sliding doors to 2 West Smoking Patio
10. Exit from Therapy gym to back patio
11. Sliding doors out to back enclosed patio
12. Back East stairwell
13. East Stairwell by Elevator

here are three monitors in the facility for the Roam Alert™ system. The first is located in front of the Main dining room across from the three main elevators. The second is the Roam Alert Server which is located at the 1 West Nurse's Station. The third is located at the 1 East nursing station.

These monitors identify which door is sounding the alarm and the tag number of the resident who has triggered the alarm. The alarm can only be reset at the door. The code is **0320#**.

Maintenance of RoamAlert System

Doors will be checked for operation by the Maintenance Director weekly. Bands will be checked daily by the cart nurses on the evening shift.

Responding to and Clearing RoamAlert Alarms

RoamAlert automatically generates alarm messages when certain events occur. In day-to-day operations, these alarms usually relate to changes in the status of tags.

Tag In Field (TIF) occurs when a tag enters the field of a controlled door and remains in the field longer than 55 seconds without the entry of the PIN code at the door keypad

- Tag Location Message (TLM) occurs when a tracking wrist tag cannot be detected. Not all residents will be assigned a tracking wrist tag. This determination will be made by the IDT and specifically assigned and care planned for individual residents.
- Tag Initiated Communication (TIC) occurs when the panic button on a pendant tag is pressed.
- Battery Low Message (BLM) occurs when a tag's battery circuit sends a low-battery signal.

When the alarm is activated it makes an audible alarm sound at the three monitors and at the door controller that was activated. The computer monitors located on 1 West, next to the Main Dining Room, and 1 East will have a flashing alarm icon appear on the floor plan where the alarm was triggered. It is the expectation that all staff are responsible for ensuring that the alarm is responded to, resident is located and re-directed, if appropriate, and that the alarm is re-set. The alarm is not to be reset unless the resident has been located or an active search is underway.

To clear a RoamAlert wander alarm:

1. Locate the resident, escort him/her to a safe location away from the door that is alarming then;
1. Enter **0320#** on the keypad located next to the door. The code will silence the door and accept the alarm on the monitor.
2. The alarm is **NOT TO BE RESET** until the resident has been located, or an active search is underway.

RoamAlert Malfunction:

Notify Maintenance Supervisor (Emergency phone numbers for leadership staff are in the red Fire and Safety Manuals which are located on each unit and throughout the facility.)

6/06, Reviewed 11/13; revised 02/15, 04/16, 12/01

PLACING A ROAMALERT WRIST BAND ON A RESIDENT.

1. Placing a RoamAlert requires an MD order.
2. Identify resident who requires the RoamAlert wrist tag, measure the residents wrist or ankle (depending on where the band will be located) with the Securaband® sizing tool. Each Securaband® has the size indicated on the inside of the strap.
3. Go to 1 East unit and obtain a RoamAlert™ wrist tag and a Securaband® in the appropriate size
4. Identify the RoamAlert Wrist Tag Serial Number and Expiration Date. This information is located on the back of the Wrist Tag.
5. Using the Pocket Tag Reader, you must test the Wrist Tag to ensure that it is working properly. If the tag is not working properly do not use and select another tag.
6. Document on the RoamAlert Bracelet Sign-out Sheet located at the 1 East Nurses station. Fully complete the sign out sheet for each resident assigned a Wrist Tag (date assigned, resident name, resident unit, wrist tag serial number, expiration date, where tag placed on resident, name of staff member assigning RoamAlert™ wrist tag.
7. Go to these six (6) alarmed exit doors and document the residents name and the RoamAlert Watch Tag Serial Number on the RoamAlert™ tracking sheet located at each exit.
 1. Main Entrance
 2. Canteen exit
 3. Door to the loading dock
 4. Exit door out to annex
 5. Back exit leading to the enclosed Smoking Area/ next to Therapy Gym
 6. Exit Door next to the library
8. Attach the RoamAlert Wrist Tag to the assigned resident using the Securaband® strap that has been identified as the proper fit for the resident. Slide Wrist Tag onto the strap with both the Wrist Tag Serial Number and the Securaband® size facing you. This will result in these also facing the resident's skin when strap applied. Position the strap around the resident's wrist or ankle and insert the free end into the clasp until it clicks into place.
9. Notify the Unit Clerk on 1 East who is responsible for assigning the RoamAlert tag into the RoamAlert software. Until assigned, the tag will still alert at all the exits and the tag serial number will appear on the RoamAlert monitors for staff responding to alarms to identify the resident at the door.
10. Notify Social Services Administrative Assistant to update resident pictures at the 6 alarmed exit doors.

STORING ROAMALERT WRIST TAGS AND SECURABANDS®

1. RoamAlert Wrist Tags and Securabands® when not in use will be stored in two locations.
 - a. 1 East Nursing unit will have Wrist Tags and Securabands® available for assignment

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- b. Central Supply will also carry unused wrist tags and bands to supply 1 East
2. Wrist tags will be stored in their original foil bags until used to prevent depleting battery life.
3. Previously used Wrist Tags will be cleaned and sanitized and then stored on 1 East and should be stored in aluminum foil to prevent depleting battery life.

CLEANING WRIST TAGS AND SECURABAND®

1. If Wrist Tag or Securaband® become soiled while applied to resident, use mild soap and water to clean. Dry tag and band with soft cloth.
2. To sanitize use alcohol sanitizer or germicidal wipe and allow to air dry.

REMOVING AND UNASSIGNING A ROAMALERT TAG

1. Removing and un-assigning a RoamAlert tag requires a d/c order.
2. Identify resident who requires the RoamAlert wrist tag removed. If the resident has on a Securaband® then use the Securaband® Removal Tool to remove the tag and wrist band. The removal tool is located on the 1 East unit with the RoamAlert supplies.
3. Sanitize the RoamAlert wrist tag and Securaband with a germicidal wipe and allow to air dry per germicidal wipe manufacturer directions.
4. Document the return of the RoamAlert Bracelet on the RoamAlert Sign-out Sheet located at the 1 East Nurses station. Find the residents name on the page when it was assigned and fill in the date discontinued and the staff name discontinuing the tag.
5. Return the Roam Alert™ wrist tag and a Securaband® to the appropriate drawer on 1 East unit.
6. Go to these six (6) alarmed exit doors and cross out the resident's name and the RoamAlert Watch Tag Serial Number on the RoamAlert™ tracking sheet located at each exit.
 - a. Main Entrance
 - b. Canteen exit
 - c. Door to the loading dock
 - d. Exit door out to annex
 - e. Back exit leading to the enclosed Smoking Area/ next to Therapy Gym
 - f. Exit Door next to the library
7. Notify the Unit Clerk on 1 East to un-assigning the RoamAlert tag in the RoamAlert software.
8. Notify the Social Services Administrative Assistant to update the resident pictures at the 6 doors.

02/15, 05/16

ELECTRIC MOTORIZED DEVICE (EMD) POLICY & PROCEDURE

Policy

It is the policy of the Idaho State Veterans Home – Boise that all residents who have an EMD will operate it in a safe manner. Within the facility environment the use of an EMD is considered a privilege, not a right, and is subject to safe practices.

Procedure

1. Any resident operating an EMD will need to do so in a safe & courteous manner and must meet the following criteria:
 - a. Resident has limited functional ambulation and has adequate vision, hearing and cognitive abilities as determined by the therapy team.
 - b. SNF resident completes the Electric Mobility Safety Checklist with Occupational Therapy with 80% or greater score, averaged over 5 trials.
 - c. Resident's designated R.N. Unit Manager, Social Worker will review recommendations made by O.T. and care plan for the appropriate use of the EMD.
 - d. EMD must be no more than 32" (thirty-two inches) in width at its widest point.
2. The resident's care plan will specify the following:
 - a. What assistance if any the resident needs to operate the EMD.
 - b. If there are any restrictions on where the resident is able to travel in the EMD.
3. Each resident who operates an EMD must be in compliance with the following safety approaches:
 - a. Pedestrians have the right of way- The EMD driver must interact with pedestrians appropriately and safely at all times, both within and outside the facility.
 - b. The EMD must be operated within the facility and on facility grounds at the lowest speed setting. The facility reserves the right to adjust the speed of the device.
 - c. All EMDs that are used outside on facility grounds need to be identified by a high-flying flag.
 - d. Any time the resident leaves the facility with the intent to maneuver the EMD they need to sign themselves out of the facility at their respectful unit. Upon signing out the resident will give an estimated return time for safety precautions.
4. Any member of the interdisciplinary team may request a re-evaluation due to an identified change in the resident's abilities.
5. The facility reserves the right to discontinue the use of the EMD if there are any safety infractions in accordance with the *Rules of the Road* and this EMD procedure.
6. The facility does not purchase/provide EMD's for resident use.
7. The facility is not responsible for repairs to personal EMD's.
8. If there is an accident or a near miss involving a resident operating an EMD that jeopardizes the safety of either the EMD driver or others, staff will inform the resident

- that an immediate intervention is required. This is implemented to assure safety, specific to the incident or resident. The RN Unit Manager will follow up on this incident and determine if there is a need for the resident to be screened &/or evaluated by O.T. If such a need is determined, then nursing will obtain the appropriate physicians order and therapy will be notified.
9. Immediate interventions may include resident education, parking the EMD, the EMD not allowed in community spaces where other residents are. If necessary, the R.N. Manager, Social Worker will be called for guidance.
 10. An incident report will be written to document the occurrence of an accident or near miss.
 - a. The incident report will be discussed at the next IDT meeting.
 - b. At the IDT meeting, the immediate intervention will be reviewed. The team will determine an ongoing action plan **based on each individual situation and the resident's physical and cognitive abilities.**
 11. The privilege to operate an EMD can be suspended for:
 - a. Resident noncompliance with plan of care
 - b. Resident can no longer operate the EMD safely as evidenced by:
 - i) Damage to the facility or EMD;
 - ii) Injury to another person or themselves'
 - iii) Careless driving around other residents and/or staff.
 - c. The EMD is no longer therapeutic for the resident.
 - d. Resident is no longer able to successfully operate the EMD &/or OT evaluation process indicates a resident is unsafe.
 - e. There is an acute physical or mental change in the residents' condition that adversely affects prior abilities to safely maneuver an EMD.
 - f. Resident does not follow the facility policy, procedure and the *Rules of the Road*.
 12. The IDT to determine length of EMD suspension on an individual resident basis. This will be communicated to resident and their POA (as appropriate). If resident is determined to be indefinitely suspended from operating the EMD, re-evaluation with OT will occur within no more than 90 days.
 13. The IDT will be responsible for updating any care plan changes as necessary.
 14. All residents who operate an EMD will review and sign a copy the ISVH-B EMD policy, procedure and *Rules of the Road* prior to utilizing the EMD within the facility or on facility grounds. A copy of the signed policy & procedure will be placed in the residents' medical record below the therapy tab.
 15. Resident will receive a copy of the signed policy and procedure, and a copy will be placed in the residents' medical record below the therapy tab.

Revised 01/16

**I have reviewed and agree to comply with the ISVH-B
Electronic Motorized Device Policy & Procedure and the
Rules of the Road.**

RESIDENT'S NAME _____ ROOM # _____

RESIDENT SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

ELECTRIC MOTORIZED DEVICE (EMD)

RULES OF THE ROAD

- Pedestrians have the right of way.
- For the safety of self and others, NO bumping, pushing or hitting any person or property.
- EMD will be operated on the lowest speed setting when operated within the facility or on facility grounds.
- Use appropriate safety when backing up your EMD.
LOOK behind you.
- Do not park your EMD in doorways or behind parked cars in the parking lot.
- Your EMD needs to be identified by a high flying flag if you will be using it outside on facility grounds.

Use increased caution when using EMD in the facility, in a parking lot or when crossing the street.

ELECTRONIC SIGNATURE ATTESTATION PROCEDURE

Purpose

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

Procedure

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.

8/14

COMMUNICATING WITH ATTENDING PHYSICIANS VIA SECURE MESSAGING

Secure conversation within Point Click Care (PCC) is the ability to send a resident's attending physician a message from PCC to the MD. The MD can respond back, and the message will be viewable in PCC. ISVH-B staff are not allowed to use their personal phones to "text" the MD's with resident issues. Messaging will be conducted ONLY through PCC. This feature is only available for the skilled nursing units of the facility, not Residential Care.

* FOR URGENT ISSUES (i.e. critical lab value, severe uncontrolled pain, nausea, or anxiety, medication error, severe low or high blood sugar, fever with positive urine dip, fever with s/s of influenza or pneumonia, new admission requiring verbal conversation of med orders so pharmacy can provide them on time) NURSING WILL STILL BE EXPECTED TO CALL MD. *

Rules for using Secure Conversations:

1. Nursing may use secure conversation for requesting orders and/or notifications. Messages will be in three categories and must start with one of the following:
 - a. **URGENT** – start the message with "Urgent orders needed, please respond within 15 minutes, for" ... (i.e. critical lab value, severe uncontrolled pain, nausea, or anxiety, medication error, severe low or high blood sugar, fever with positive urine dip, fever with s/s of influenza or pneumonia, new admission requiring verbal conversation of med orders so pharmacy can provide them on time). THEN FOLLOW UP WITH A PHONE CALL IMMEDIATELY.
 - b. **NON-URGENT** – start message with "Non-urgent orders needed, please respond by 5pm today for" ... (i.e. PT/INR out of range but not critical value, positive urine dip without fever, urine culture results which may require change in antibiotics in afebrile resident).
 - c. **FYI ONLY** – start a message with "FYI Only, please acknowledge receipt of message for" ... (i.e. non-injury or minor injury fall, expected death, res-to-res incident not requiring urgent orders).
2. Nursing is required to create a **progress note after every response from the physician**. In the resident's chart under their picture there is an area that says "Conversations". Next to every message in that area there is a grey box with white lines to the left of the message. Click on that and there is the heading "create progress note". Once you have done this, reply to the message with the phrase "PN Created".
3. When sending a message, your '**Participants**' will always be the **Unit Group** of the unit the resident lives on (1 West, 2 West, 1 East). This ensures that all those involved in the care of that resident are receiving the message. Nurses that float to all 3 units are in all message groups so pay careful attention to the messages for the residents that you are caring for that day.
1. The log sheets in the communication book now have 2 extra columns in yellow for "Sent PCC Secure Message" and "Response Received from Physician". Please place a check in

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the appropriate box once you have sent a message concerning that issue and received a response from the physician. If you are taking a 'call-in' or 'call-out' from Dr. Smith, you **DO NOT** need to discuss with him any issue that has a check in **BOTH** yellow boxes.

03/16, 05/16, 08/17

DENTAL SERVICES

Purpose

Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.

Procedure

1. Routine and 24-hour emergency dental services are provided to our residents through:
 - a. A contract agreement with a licensed dentist that comes to the facility monthly;
 - b. Referral to the resident's personal dentist;
 - c. Referral to community dentists; or
 - d. Referral to other health care organizations that provide dental services.
2. A list of community dentist available to provide dental services to our residents is posted at each nurses' station and the list is also available from Social Services.
3. Residents have the right to select dentists of their choice when dental care or services are needed.
4. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.
5. Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures.
6. Dentures will be protected from loss or damage, to the extent practicable, while being stored.
7. Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures.
8. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.
9. All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred.

08/17

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

1. 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.
2. 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.
3. 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.
4. In addition to the above, facility staff or other interested parties may ask the Committee to evaluate other concerns within the facility.

Quality Measure

1. The RAI – 16 QM indicators will be reviewed in the QA Committee.
2. The Director of Nursing Services (or designee) is responsible for obtaining the facility's QM profile, reviewing each of the areas and developing plans of action for each item above the 75th percentile rank, those items which are “flagged” or identified as a sentinel event.

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 QM 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, and person 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.

01/01, revised 06/01, 02/03, 07/03, 12/03, 10/08, 04/12

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) PLAN

Vision

The Idaho State Veterans Home is “Caring for America’s Heroes.” The goal of the Idaho State Veterans Home is to assist residents in attaining or maintaining their highest level of independence within the least restrictive environment. The Idaho State Veterans Home is dedicated to transitioning residents to independent living in the community whenever possible.

Mission

We are dedicated to serving Idaho’s veterans and their families by providing superior advocacy, excellent assistance with benefits and education, high quality long-term care, and respectful interment services in a dignified final resting place.

Purpose

The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents, caregivers, and other partners so that we may realize our vision to assist residents in attaining or maintaining their highest level of independence within the least restrictive environment. To do this, all employees will participate in ongoing QAPI efforts which support our mission by providing high quality long-term care while caring for American heroes.

Guiding Principles

The Idaho State Veterans Home-Boise (ISVH-B) will use guiding principles to direct what the facility does, why it does it, and how it does it as relates to QAPI.

1. Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
2. The outcome of QAPI in our organization is to improve the quality of care and the quality of life of our residents.
3. In our organization, QAPI includes all employees, all departments, and all services provided.
4. QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
5. Our organization makes decisions based on data which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
6. Our organization sets goals for performance and measures progress toward those goals.

Scope

The scope of the QAPI program encompasses all segments of care and services provided by the ISVH-B that impact clinical care, quality of life, resident choice, and care transitions with participation from all departments.

Segments of Care	Services Rendered
Clinical Care Services	We provide comprehensive clinical care to residents with acute and chronic disease, rehabilitative needs, as well as end-of-life care. All care is resident-centered and focused around choice and individualized treatment plans. We strive to meet each resident’s goals of care, including developing and executing a transitional plan for discharge back to the community.
Dietary	We provide nutritious meals under the supervision of a licensed dietician. We consider resident choices and preferences by providing several options for meals and embrace open dining hours.
Pharmacy Services	We provide supervision and collaborate with the medical and nursing team at the ISVH-B by reviewing, dispensing, and monitoring medication effectiveness to ensure therapeutic goals are maintained for each and every resident.
Maintenance and Engineering	We provide comprehensive building safety, repairs, and inspections to ensure all aspects of safety are enforced, assuring the safety and well-being for each resident, visitor, and staff who enters the building.
Housekeeping	We provide and ensure that all health and sanitation requirements are met through regular cleaning, disinfection, and sanitation of all aspects of the building.
Administration	We align all business practices to ensure every resident has individualized care, and we work to support the providers with the resources and equipment to meet the care goals of those we care for.

The QAPI program at the ISVH-B will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for by ensuring our data collection tools and monitoring systems are in place and are consistent for a proactive analysis.

We will utilize the best available evidence (such as data from the Trend Tracker, CASPER Report, national benchmarks, published best practices, and clinical guidelines, etc.) to define and measure our goals.

QAPI Plan Goals Governance and Leadership

The governing body and/or administration of the nursing home will develop a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI;

The ISVH-B governing body is ultimately responsible for overseeing the QAPI Committee. The Administrator has direct oversight responsibility for all functions of the QAPI Committee and reports directly to the governing body. The QAPI Committee shall include, but not limited to, the Administrator or other individual in a leadership role, Director of Nursing Services, Medical Director or designee, the Infection Control and Prevention Officer. The QAPI Committee is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction.

A facility-wide training will be conducted to inform everyone in the facility about the QAPI plan at the ISVH-B. These trainings will be conducted often and in multiple ways through regular all-staff meetings, department staff in-services, change-of-shifts report time, etc. Every caregiver will be made to understand that they are expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

The QAPI approach at the ISVH-B will also be communicated to consultants, contractors, and collaborating agencies, to make them understand that they each have a role in the QAPI plan.

Feedback, Data Systems, and Monitoring

The ISVH-B will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences.

The QAPI Committee at the ISVH-B will decide what data to monitor routinely. Areas to consider may include, but not be limited to, the following examples:

1. Clinical care areas (e.g., pressure ulcers, falls, infections)
2. Medications (e.g., those that require close monitoring, antipsychotics, narcotics, medication errors)
3. Complaints from residents and families
4. Hospitalizations and other service use

5. Resident satisfaction
6. Caregiver satisfaction
7. Care plans, including ensuring the implementation and evaluation of measurable interventions
8. State survey results and deficiencies
9. Results from MDS resident assessments
10. Business and administrative processes (e.g., financial information, caregiver turnover, caregiver competencies, and staffing patterns, such as permanent caregiver assignment).

Thresholds for performance in the areas that are being monitored will be set by the QAPI Committee. The threshold will usually be stated as a percentage.

Benchmarks for performance such as TrendTracker, Nursing Home Compare, CASPER report, facility's own performance, etc. will be used to monitor the facility's progress.

Performance Improvement Projects

The QAPI Committee at the ISVH-B will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements.

Examples of potential areas to consider when reviewing data include:

1. MDS data for problem patterns
2. Nursing Home Compare State survey results and plans of correction
3. Resident care plans for documented progress towards specified goals
4. Trends in complaints
5. Resident and family satisfaction for trends
6. Patterns of caregiver turnover or absences

Based on the result of the review of information, the QAPI Committee at the ISVH-B will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI Committee will determine which problems will become the focus for a performance improvement project (PIP). The facility will conduct a minimum of one performance improvement project annually.

Systematic Analysis and Systemic Action

The ISVH-B uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The ISVH-B applies a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. The ISVH-B's approach comprehensively assesses all involved systems to prevent future events and promote sustained improvement. The ISVH-B also has developed policies and procedures regarding expectations for the use of root cause analysis when problems are identified. This element includes a focus on continual learning and continuous improvement.

Communication

At a minimum, the executive leadership will report annually on the status of the current QAPI plan, the proposed QAPI plan, and goals for the coming year. This report will be made available to:

- Corporation/Board of Directors
- Entire management team of the ISVH-B
- Staff
- Resident/family council
- Other stakeholders, as designated

Evaluation

At a minimum, the executive leadership and facility management teams, along with the assistance of the QAPI Steering Committee, will conduct a facility-wide systems evaluation using the QAPI Self-Assessment. The team will thoughtfully and thoroughly consider the progress made in the last year toward achieving the designated QAPI goals and current status of measurement in meeting and sustaining the performance indicators. Other factors to consider will be current trends in the long-term care industry as well as strategic goals for the facility. Gaps in systems and processes will be identified and addressed in the coming year's QAPI plan.

08/17

RESIDENTS' RIGHTS REGARDING TREATMENT AND ADVANCE DIRECTIVES

Purpose

It is the resident's right to formulate an Advance Directive, and to accept or refuse medical or surgical treatment.

Explanation and Compliance Guidelines

1. On admission, the facility will determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive.
2. Upon admission, should the resident have an Advance Directive, copies will be made and
3. placed on the chart as well as communicated to the staff.
4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capabilities.
5. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate.
6. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to the Advance Directives.
7. Decisions regarding Advance Directives and treatment will be addressed with any significant change or improvement.
8. Any decision making will be documented in the resident's medical record and communicated to the interdisciplinary team.
9. The facility will not discharge a resident should they refuse treatment either through an Advance Directive or directly.
10. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart:
 - a. What the resident refused.
 - b. The reason for the refusal.
 - c. The advice given to the resident about the consequences of refusing.
 - d. The offering of alternative treatments.
 - e. The continuing of providing all other services.
11. The facility will not initiate or discontinue any other care based on refusal of care by the resident.
12. The facility will use the process as provided by State law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes.

12/17

CARE PLAN ACKNOWLEDGEMENT – RESIDENT/REPRESENTATIVE - FORM

My signature below specifies that I have:

1. Discussed
2. Viewed my plan of care and was given the opportunity to ask questions and state my preferences in my care and goals of care.

Items reviewed and/or provided:

- Baseline care plan
- Comprehensive care plan
- POST/Advanced Directives/Mortuary
- Current medication list
- Current treatment list
- Current labs
- Current discharge goals or plans

Signatures:

Resident: _____ Representative:

Licensed Nurse: _____ Social Services:

C.N.A. _____ Activities:

Restorative: _____ Rehab:

Others: _____ Others:

Date:

Resident Name:	Room #:
----------------	---------

Elopement Check List

1. Ensure the resident is not on an activity away from the nursing unit or on leave from the facility:

- Activities
- Family
- On outing
- Appointment

2. Institute a thorough search of the entire unit.

- Check all resident rooms on both halls to include resident bathrooms
- Shower Rooms
- Utility and storage rooms
- Common areas
- Unit balconies
- Nursing station
- Staff break room
- Offices

3. Call all other nursing units and the Dom/Residential care unit and describe the resident. Each unit (1 East, 2 East, 1 West and 2 West) will search their entire unit to include:

- Check all resident rooms on both halls to include resident bathrooms
- Shower Rooms
- Utility and storage rooms
- Common areas
- Unit balconies
- Nursing station
- Staff break room
- Offices

4. Send a caregiver, on the zone where the resident is missing, to look on the Main floor in all hallways and common areas, including but not limited to:

- Dining Room
- Lobby/Canteen
- Library/Activity Room
- All Stair Wells
- Kitchen
- Therapy Gym
- Chapel
- Court yards
- Smoke Room

- Beauty Shop
- Business office and other offices
- Bathrooms

5. Two caregivers will be sent to walk around the perimeter of the Idaho State Veterans Home.

6. Seek assistance from the security contractor, M & T Patrol Services 376-6853, available between the hours of 2030 and 0430) to search the VA and grounds.

7. Call the RN Manager of the unit to report the incident.

8. If the resident has not been located after the above steps have been completed the licensed nurse on the unit will notify:

Resident's family

- Director of Nursing
- Maintenance & Operations Supervisor
- IT Department
- Home Administrator
- Social Services Director
- Ada County Dispatch (377-6790)

06/17

I have reviewed and agree to comply with the ISVH-B Electronic Motorized Device Policy & Procedure and the Rules of the Road.

RESIDENT'S NAME _____ ROOM # _____

RESIDENT SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

ORDER REVIEW

Pharmacy Review:

1. Comments:

2. Dosing safety/recommendations:

I have reviewed the facility's monthly physician orders.

Pharmacist Signature: _____ Date: _____

Nursing Review and Comments:

I have reviewed the facility monthly physician orders and the pharmacy review above.

Nurse Signature: _____ Date: _____

Physician Review and Comments:

I have reviewed the facility monthly physician orders, the pharmacy review and the nursing comments above.

Physician Signature: _____ Date: _____

Director of Nursing Services Signature: _____ Date: _____

Orders noted/reviewed by (Nurse Signature): _____ Date: _____

Idaho State Veterans Home – Boise
Nursing Procedure Manual

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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 Admissions Coordinator or Social Worker who places the applicant on the waiting list. The list is prioritized according to level of care and

room availability. The applicant is reviewed by the Admissions Coordinator and placement to the proper unit is determined, then the Unit Manager for that unit reviews the admission paperwork to identify that ISVH can meet the potential resident's needs. 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 manager, the assigned caregiver and the unit 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 and on the resident's face sheet.

Admission Lab and X-Ray Procedures (Protocol)

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

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

Pneumococcal vaccines (if applicable)

Influenza Vaccine (as available/appropriate time of year)

Revised 10/03, 11/13, 08/18

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 require skilled nursing 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 device.
 - 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 or without exertion), cough, sputum production.
 - g. **Cardiac status** – heart rate, is it regular/irregular, any c/o chest pain, pedal pulses.
 - h. **GI status** –document abdominal sounds, any c/o abdominal pain, tenderness with palpation/exam, any c/o GI distress (heartburn, N/V, abdomen distention, constipation, and 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, and toleration of tube feedings/water flush.
 - j. **Functional ability** – document amount of assist required for:

Bed Mobility	Eating	Toileting	Dressing
Transfer	Hygiene	Ambulation	W/C mobility
 - 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?

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- l. **Pain Management** – any c/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 (bruise, abrasions, rash, ulcer) with description of wound, drainage, odor, treatment, interventions in place to prevent skin breakdown (mattress, cushion in w/c, posey boots, geri gloves lotion, etc.).Especially important to document any treatments done during the admission assessment. Edema-where, how much
- n. **Notification of MD** – regarding resident arrival and verification of orders.

9/07, Reviewed 11/13

MEDICARE DOCUMENTATION GUIDELINES

Purpose:

To justify Medicare A coverage with accurate assessment/documentation.

Procedure:

1. When a resident is admitted under Medicare A benefit status, the Medicare Nurse/RN Manager shall “set-up” the resident in the unit’s Medicare A charting log (refer to our Alert Charting book – Med A tab).
2. The Medicare Nurse/RN Manager shall designate the name of the resident and the specific documentation that will be required.
3. The assessment will be documented on the BVH Medicare A Skilled Charting assessment in Point Click Care (PCC) Assmnts tab.
4. The licensed nurse will document on each Medicare A resident assigned on that particular shift per the Medicare A Charting Log.
5. The licensed nurse will document any change in condition under the Progress Note section of the specific resident’s medical record in Point Click Care (PCC).

There are Medicare “buzz words” that are frequently found in the regulations - using these words or addressing the concept of the word/phrase provided, as applicable, will help to ensure proper Medicare documentation. The words will be utilized, as appropriate, when documenting to any abnormal findings/assessments. These words/phrases are as follows:

1. Safety
2. Likelihood of change
3. Danger of reoccurrence
4. Medical complications
5. High risk factor
6. Reasonable probability
7. Aggregate of non-skilled services
8. Prevention deterioration
9. Potential for complication
10. Observation and assessment
11. Management of resident’s medical needs
12. Promote recovery and ensure medical stability
13. Safe and effective delivery
14. Special medical complications
15. Prior level of function

The following are guidelines that may assist the licensed nurse in assessing and documenting – based on specific diagnoses:

MEDICAL DIAGNOSIS

Guidelines for assessment/documentation

List of medical diagnosis: (refer to expanded description for documentation requirements)

- Aggregate of Unskilled Services Amputation – above the knee Amputation – below the knee Anemia
- Bladder, neurogenic Cancer
- Cast care
- Cerebral Vascular Accident (CVA) Colostomy/urostomy Comfort/Terminal Care Congestive Heart Failure (CHF) Decubitus Ulcer/Wounds
- Diabetes
- Gastro-intestinal bleed Gastrostomy/NC/Jejunostomy Hip Fracture
- Hypertension Myocardial Infarction Pain
- Pneumonia – Upper Respiratory Infection Psych Medication Changes
- Renal Failure Seizure Disorder Tracheostomy
- Urinary Tract Infection

EXPANDED DESCRIPTIONS

Aggregate of Unskilled Services

1. Describe any medication adjustment
2. Evaluate neuro status – when appropriate
3. Describe if a resident is comatose, semi-comatose status
4. Evaluate nutritional status
5. Describe Skin appearance, pressure areas, etc.
6. Discuss pain control.
7. Assess for rales in chest – suction required?
8. Note general nursing observation e.g. signs of deterioration, identify and evaluate the resident's need for possible modification of treatment, or initiate new procedures.
9. Note type of progress resident is making – e.g. becoming more independent with ADL's etc.
10. Determine if resident has proper body alignment to avoid contractures, deformities.

Amputation – above the knee

1. Obtain vital signs daily, especially temperature
2. Assess wound site and condition
3. If dressing is applied, describe dressing/treatment
4. Conduct edema checks
5. Note any callus formations
6. Assess applications and progress of stump shrinker
7. Assess for unaffected foot for foot drop

8. Note “phantom” pain, where, when, type, duration, how treated and the results of treatment
9. Note ambulation status
10. Note depression and results of medication, if any given
11. Assess for development of contractures
12. Note use of prosthetic device
13. Discuss participation in PT/OT program.

Amputation – below the knee

1. Obtain vital signs daily
2. Conduct Edema and circulation checks daily
3. Assess for development of contractures
4. Assess for any callus formations
5. Check unaffected foot for foot drop
6. Assess balance, standing and sitting
7. Note any phantom pain, where, when, type, duration, how treated and the results of treatment
8. Assess application and progress of stump shrinker
9. Note ambulation progress
10. Assess wound site and condition
11. If open wound, describe treatment
12. Discuss participation in therapy programs

Anemia

1. Obtain Vital signs daily
2. Evaluate Nutritional intake
3. Conduct edema checks - ? Tingling lower extremities?
4. Assess for mouth sores
5. Assess pallor, fatigue
6. Assess for dizziness/faintness
7. Assess for headaches, ringing in ears
8. Assess for dyspnea
9. Assess for pale mucous membranes, nail beds, and conjunctiva
10. Assess for presence of palpitations

Bladder, neurogenic

1. Assess results of catheter/intermittent catheterization, etc.
2. Observe for s/s of infection – vital signs, concentrated urine, purulent urine
3. Assess for adequate oral intake
4. Describe irrigations is applicable
5. Discuss bowel and/or bladder training if applicable
6. Evaluate results of PVR if applicable.

Cancer

1. Obtain vital signs daily.
2. Evaluate weight/anorexia issues
3. Evaluate mental status
4. Evaluate endurance/fatigue/activity/mobility status
5. Discuss medical interventions, reactions to interventions such as radiation, chemotherapy

Cast Care

1. Describe location of cast
2. Assess for adequate pain control, discuss amount and frequency of medications given
3. Assess circulatory status
4. Assess mobility restrictions
5. Assess for presence of edema, treatments
6. Assess for proper positioning

Cerebral Vascular Accident (CVA)

1. Describe assistance needed with ADL's
2. Describe assistance needed for bed mobility and positioning
3. Assess for problems with balance and impact on level of function
4. Assess for edema on affected side
5. Assess for speech impairments – ability to make needs known
6. Discuss restorative or other therapy programs
7. Obtain vital signs daily, particularly BP
8. Note any appliances needed/in place

Colostomy/Urostomy

1. Assess ostomy site
2. Describe stool frequency/urine consistency
3. Assess for abdominal distention – bowel sounds
4. Assess for post-op complications such as infection of wound
5. Describe teaching progress, including resident's learning capabilities, response
6. Describe irrigation frequency and results if applicable

Comfort Care/Terminal Care

1. Describe nursing interventions and why
2. Describe chemotherapy/radiation if applicable + side effects
3. Assess nutritional status
4. Assess skin integrity and treatments
5. Discuss medication changes and response
6. Discuss resident/family grief counseling,
7. Assess for pain management and response
8. Discuss mood/behaviors

9. Describe oxygen/suctioning
10. Describe advance directive
11. Describe lab test results
12. Describe communication/involvement with/from resident's family/friends

Congestive Heart Failure (CHF)

1. Obtain vital signs daily, noting pulse irregularities
2. Auscultate lungs, assess for presence of rales, etc.
3. Assess for presence of edema
4. Describe diuretic therapy
5. Describe response to medications e.g. digoxin
6. Evaluate for SOB – oxygen use if applicable
7. Describe ADL status

Decubitus Ulcer/Wounds

1. Describe location
2. Assess wound status
3. Describe wound dressing
4. Describe pressure-relieving interventions if applicable

Diabetes

1. Describe whether insulin dependent or oral medicated
2. Describe results of accu-checks
3. Evaluate nutritional intake
4. Assess skin
5. Assess for s/s of infection
6. Assess for s/s of hypo or hyperglycemia
7. Evaluate results of applicable lab tests

Gastro-intestinal Bleed

1. Obtain vital signs daily
2. Describe weight – loss or gain
3. Describe any bloody sputum, emesis, tarry stools
4. Assess for ambulation, ADL status
5. Evaluate results of applicable lab tests

Gastrostomy/NG/Jejunostomy

1. Describe feeding schedule/amounts, etc., including any adjustments or changes in formula, schedule
2. Assess condition of insertion site
3. Describe resident's reaction/tolerance to tube feedings

Hip Fracture

1. Evaluate assistance needed for bed mobility, positioning, and transfers.
2. Describe resident's weight bearing status
3. Document degree of assistance needed with ADL's and endurance level
4. Assess for need and response to pain medications
5. Evaluate mental status – ability to cooperate
6. Assess suture site and describe dressing if applicable
7. Assess for presence of edema of affected extremity
8. Describe resident's response to therapy

Hypertension

1. Obtain vital signs daily
2. Evaluate weight
3. Assess for confusion, blurred vision/vertigo, change in mental status, headaches, side effects of hypertensive medications
4. Assess balance when ambulating
5. Describe diet

Myocardial Infarction

1. Obtain vital signs daily, including noting any irregularities in pulse
2. Describe progression of ambulation, tolerance, SBO, chest pain on exertion
3. Describe diet and resident's response to diet
4. Evaluate resident's response to medications
5. Note any nausea and/or vomiting
1. Evaluate mental status
2. Describe resident's ADL status

Pain

1. Describe skilled nursing interventions provided and why
2. Describe cause and type of pain include frequent and intensity (use pain scale or resident's reaction to pain e.g. grimacing)
3. Describe specific interventions to alleviate pain and resident's response to intervention
4. Describe medication changes including effectiveness, side effects, adverse reaction and tolerance
5. Describe resident/family communication/teaching

Pneumonia – Upper Respiratory Infection

1. Obtain vital signs
2. Auscultate lungs, describe findings
3. Describe sputum
4. Assess for resident's ability to cough, deep breath
5. Describe nutritional status, appetite
6. Assess ADL status including mobility, endurance

7. Describe breathing treatment response, ABO therapy/response
8. Describe oxygen therapy, response (SAT)

Psych Medication Changes

1. Describe skilled nursing interventions provided and why.
2. Describe how behaviors adversely affect the plan of care and/or resident's recovery
3. Describe medication, interactions, side effects and effectiveness, include any medication changes and effect on resident
4. Describe self-care deficits
5. Assess sleep/awake cycles.
6. Describe resident's participation in activities
7. Describe resident's nutritional intake/weight changes
8. Describe mood/behavioral changes and any behaviors that place resident at risk of self or others
9. Review lab tests and results
10. Describe communication and/or teaching with resident/family

Renal Failure

1. Obtain vital signs daily
2. Evaluate weight
3. Assess for fatigue, ADL status
4. Assess for nausea/vomiting
5. Assess breath for ammonia
6. Assess edema
7. Assess mental status – delusions, disorientation, anxiety, irritability
8. Assess skin, muscles for twitching/itching
9. Assess/describe arm shunt if applicable
10. Describe dialysis schedule if applicable

Seizure Disorder

1. Describe time began/ended, symptoms at beginning, pattern of seizures, type.
2. Describe resident's movements during seizure
3. Describe incontinence, LOC changes
4. Obtain vital signs post seizure
5. Note any injuries sustained during seizure
6. Note PRN post-convulsive medication given
7. Describe resident's condition following seizure

Tracheostomy

1. Obtain vital signs daily
2. Evaluate nutritional intake

3. Describe suctioning and resident's response if applicable
4. Describe oxygen therapy
5. Assess trach opening
6. Describe other trach interventions if applicable such as plugging of trach

Urinary tract infection

1. Describe frequency, urgency, burning
2. Obtain vital signs daily
3. Assess fluid intake
4. Assess for chills, nausea, vomiting
1. Assess urine for blood, pus, concentration
2. Assess for pain in bladder region/back
3. Assess for reaction to ABO
4. Describe if Foley catheter is in place or other bladder voiding interventions

9/07, Revised 01/08, 05/08, 06/08, 09/14, Reviewed 11/13

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MEDICARE A CHARTING LOG

Medicare A charting will be done every day as long as the resident remains on Medicare A funding source.

The Medicare A Nurse &/or the Unit's RN Manager will discontinue this required documentation when the resident is no longer Med A status.

DATE	RESIDENT'S NAME	ROOM #	SHIFT RESPONSIBLE FOR CHARTING	ITEMS TO BE ASSESSED/DOCUMENTED Be specific and complete in your documentation – address all of the items listed in the documentation guidelines located at the front of the nurses notes in the resident's medical record. Reference can also be made to the located in Section III of the Nursing Procedure Manual

1/08

PROFIT DISBURSEMENT POLICY

In the event of a resident's death, the following policy will be followed in regard 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 must be listed on 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. 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 doing the inventory and taped to the box. When completed, contact the storekeeper who will secure the items in the basement storeroom.
2. When the family comes to collect the property, the person collecting the items shall sign and date the Patient Inventory Form. If the family would like to donate any items, a donation statement is on the back of the form. The form will then be given to the Health Information Manager to be placed in the resident's file.
3. In the event of death on the weekend or after business hours, nursing will handle storage or disbursing of physical property. Cash is to be given to the business office during regular business hours by nursing.
4. Any money left in the resident's account will be handled by the business office according to the Idaho State Veterans Home's procedures.

Reviewed 11/13

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.

Severely demented residents on the secure unit may be ambulatory, but cognition in swallowing, eating, toileting, and speaking ability may simply be absent.

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. May be preparing for discharge to our Shelter Care Unit after appropriate patient education and structural orientation.

Revised 03/02, Reviewed 11/13

CENSUS PROCEDURE

A nurse on each of the nursing units is responsible for filling out the Midnight Census report at midnight for the unit they are assigned to work.

1. Admissions Portion

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

2. Discharge Portion

All residents discharged will be listed by name, time they discharged, and where they were discharged to. *

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.

The Health Information Manager collects the Midnight Census reports from each skilled unit and from residential care unit and compiles the information into the Daily Census Report that is then distributed to all pertinent parties, e.g. Administrator, DNS, Business Office...

The Daily Census Report also contains a synopsis of residents admitted and discharged, total number of patients in facility, payment types, and the signature of the Home Administration.

*If the resident expires, indicate the time they died, not the time the body was picked up. 02/03,

Revised 10/10, Reviewed 11/13

IDAHO STATE VETERANS HOME - BOISE MIDNIGHT CENSUS REPORT

Date: _____

SKILLED NURSING CENSUS _____

ADMISSIONS

Residents Name	Admitted From	Time	Room/bed

DISCHARGES

Resident Name	Discharged To	Time

ROOM/BED TRANSFERS

Resident Name	From Room/Bed	To Room/Bed

LEAVES/PASSES

Resident Name	To	Time	Date Returned	Time

Hospital Leave/Return (only if gone less than 24 hours)

Resident Name	Hospital	Time Left	Time Return

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Today's Date:
Date Occurred:

ADMINISTRATOR: _____

NURSING

CENSUS: 1 EAST: 1 WEST: 2 WEST: TOTAL:

PAY TYPES: MCD: MCR: PVT: SC:

ADMISSIONS	UNIT	ROOM NO.	TIME	FROM	PAY SOURCE
DISCHARGES	UNIT	ROOM NO.	TIME	TO	COMMENTS
ROOM TRANSFERS	FROM ROOM #		TO ROOM #		
BED HOLDS	UNIT	ROOM NO.	DATE	HOSPITAL	

RESIDENTIAL CARE CENSUS: 33

ADMISSIONS	ROOM NO.	TIME	FROM
DISCHARGES	ROOM NO.	TIME	TO
LEAVE/PASSES	ROOM NO.	TIME OF DEPARTURE	TIME OF RETURN
ROOM TRANSFER	FROM ROOM #		TO ROOM #

24- HOUR / RESIDENT INFORMATION 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 hall/cart).
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 Unit Manager's in-box.

Revised 02/03, 11/06, Reviewed 11/13

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 of jurisdiction (**Director's Office, 208-422-1100, Boise VAMC, 500 Fort Street, Boise, ID 83702**) 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 for review. 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. The VAMC requests that this report be formatted on the VAMC Issue Brief Cover Page template and VAMC Issue Brief Template. These two pages are then securely emailed to the Boise VAMC contact person.
4. The VA sentinel event log will be completed by the Administrator (or designee) and will be located in the Health Information Manager'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 reported the event to the VA.

06/01, 03/11, 11/13

RESIDENT TRANSPORTATION / TRANSFER

Emergency Transport

1. Residents, unless otherwise specified in the medical record or as directed by the resident's physician, will be transported to the VAMC.
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 will be transported to the hospital using the following guidelines:
 - A. If resident is suspected to have an injury, then 911 or Ada County Dispatch *(377-6790) should be utilized, depending on the urgency/severity of the injury.
 - B. If resident is experiencing cardiac or respiratory distress such as difficulty breathing, chest pain, or other severely acute illness, then 911 or Ada County dispatch *(377-6790) should be utilized, depending on the urgency/severity of the illness. (Intervene as appropriate including CPR in the event of an arrest if resident has "full code" advance directives.)
 - 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 or shortness of breath, then 911 or Ada County Dispatch *(377-6790), should be utilized depending on the urgency of the situation.
 - D. If resident is not experiencing cardiac or respiratory distress or a suspected injury and does not have acutely abnormal vital signs, then resident should be transported via the facility van or other ground transportation.
5. For 911 emergency transports and non-emergency transports occurring after normal business hours, a CNA shall wait for the responders in the front lobby and escort them to the resident's room when they arrive.
6. For non-emergent ambulance transports that occur during normal business hours, the nurse shall notify the business office of the unit, room number and the estimated time of arrival of the transport vehicle. Business office personnel will escort the responders to the appropriate unit.

*Note: When contacting dispatch and are routed to a transport service that indicates an extended delay (e.g. > 30 minutes), depending on the urgency of the situation, inquire if a more timely transport is available.

Reviewed 11/13, 04/16

APPOINTMENTS AND TRANSPORTS

1. The Unit Clerk will take off order for appointment or receive appointment time.
2. The Unit Clerk will enter appointment into the Outlook transport calendar.
3. The calendar will be checked daily by the Transportation Aide.
4. The Unit Clerk will notify nursing of daily appointment the morning of the appointment.
5. The Transportation Aide will follow through with the appointments.
6. If there are conflicts with appointment times, the Unit Clerk will attempt to reschedule. If appointment cannot be rescheduled and the Transportation Aide is not available for transport, then the unit where the resident(s) resides will be responsible for transport.

Transportation Action Times

The following action times will be utilized to provide a consistent scheduling tool.

VAMC	15 min.	Meridian	45 min.
St. Luke's	20 min.	Across Town	40 min.
St. Al's	30 min.	Nampa	1 hr.
Downtown	30 min.	Caldwell	1 hr.

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

Transportation Aide Notification

To establish immediate communication with Transportation Aide:

1. Call the Transportation Aide using cell phone number: (208) 919-4462; leave message if Transportation Aide does not answer.
2. If no answer, send the Transportation Aide an email.

02/01, Revised 10/03, 01/04, 08/05, 02/06, 04/08, 09/09, 11/09, 5/10, Reviewed 11/13, 04/16

HEALTH CARE FACILITY TRANSFER/ DISCHARGE PROCEDURE

In the event a resident is discharged or transferred from the facility, the following steps will be initiated:

1. Obtain discharge/transfer/physician consultant order from resident's primary physician.
2. Put discharge order in PCC.
3. Send with Resident (or prior to transfer) copies of the following:
 - a. Face Sheet (Resident demographic information)
 - b. POST
 - c. Physician discharge order
 - d. Medication Administration Record (MAR)
 - e. Treatment Administration Record (TAR)
 - f. Most recent lab and x-ray results.
 - g. The latest Physician Progress notes
 - h. 24 hours of Nursing Progress notes
 - i. Bed Hold Policy
 - j. Notice of Resident Transfer form
 - k. Med A Hospital Notification form (only for Med A residents)
 - l. Care Plan
4. Make copies of completed Notice of Resident Transfer form and Med A Hospital Notification form (if applicable), and put in unit clerk's box to be scanned into the medical record.
5. Notify family or responsible party.
6. If resident is transferred to an acute care facility communicate pertinent resident health information (preferably nurse to nurse).
7. Put discharge progress note in PCC.

If transfer of the resident is unplanned and/or the result of an emergency related to an acute change of condition, the licensed nurse caring for the resident will notify the following personnel:

1. RN Unit Manager
2. Director of Nursing Services
3. Administrator

If the discharge is to home or another facility (return not anticipated):

1. Check valuables list to make sure all items are accounted for.
2. Obtain special diet information or specific prosthetic devices needed if resident is going to home setting or shelter care environment.
3. Interface with home health for follow up care if indicated and ordered.
4. Send comprehensive care plan to receiving facility.

10/99; Reviewed 11/13, 04/16; Revised 09/08, 12/11, 11/14, 10/15, 04/17, 12/17

BED HOLD POLICY

When a resident goes to the hospital or temporarily leaves the facility for any reason and wishes to come back to the same room, the resident/legal representative may request the facility hold the resident's room and bed until the resident returns. Except as otherwise approved by the Home Administrator, the transfer of a resident to the hospital or other care facility is a voluntary discharge unless the resident or legal representative requests a bed hold under this policy.

If the resident/legal representative does not choose to be voluntarily discharged and requests to have the resident's bed held:

- Private pay resident and Medicare beneficiaries will be charged the basic room rate and the current VA per diem rate for each day of the bed hold, unless the VA per diem is waived by the Home Administrator.
- If the resident is a Medicaid beneficiary and Medicaid agrees to pay for the bed hold, the facility will bill Medicaid up to a maximum number of bed hold days covered by Medicaid. The resident or legal representative will be billed for the resident's co-payment and current VA per diem rate, as applicable, unless the VA per diem is waived by the Home Administrator.
- Veteran resident's receiving VA benefits may have their bed held for up to 10 continuous days for any hospital stay, and up to 12 days per year, in aggregate, for any home/therapeutic leave, provided that the facility is maintaining 90% occupancy. Any resident taking leave beyond these requirements will be charged the current daily rate applicable and the current VA per diem rate, unless the VA per diem rate is waived by the Home Administrator.

In accordance with State, Federal and VA regulations, written notification of this policy will be provided to the resident/legal representative upon admission. Written notification will also be provided at the time the resident is immediately transferred or scheduled for hospitalization or therapeutic leave.

Bed hold provision are a complicated resident specific matter and should be discussed with the Business Office anytime the resident is away from the facility for hospitalization or therapeutic leave. To request bed hold for a leave of absence, please contact the Business Office or Social Service department. Overall agreements should be made with the Business Office or Social Service department within twenty-four (24) hours or the first working day after the weekend.

(2/12, 3/14), Added to NPM 12/17

Idaho State Veterans Home – Boise
Nursing Procedure Manual

NOTICE OF RESIDENT TRANSFER

Date of Notice:			
Name: Idaho State Veterans Home - Boise			
Address: 320 Collins Road	City: Boise	State: Idaho	Zip: 83702
<p>As per the admission agreement, the facility must transfer a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services. This notice is to inform you that (Resident Name) _____</p> <p>Will be transferred to (location) _____</p> <p>for the following reason(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> The transfer is necessary for the resident's welfare and the resident's needs cannot be met in this facility. <input type="checkbox"/> The safety of individuals in the facility is endangered by the resident being here. <input type="checkbox"/> The health of individual is endangered. <input type="checkbox"/> Therapeutic leave has been scheduled from (date) _____ to (date) _____ <p>The decision to transfer was discussed and agreed to by the resident's physician.</p>			
Staff Signature/Title: _____		Date: _____	
<p><u>Involuntary Discharges and Appeal Rights</u></p> <p>In the event it has been determined that you cannot return to the facility a Notice of Discharge will be provided to you or your representative and the Office of the State Ombudsman. Residents have the right to appeal to the state the facility's decision to involuntary discharge. A written notice, regarding the circumstances of involuntary discharge, will be made by the facility pursuant to federal and state requirements. Notices concerning involuntary discharges will contain the resident's right to request a fair hearing through the Idaho Department of Health and Welfare, Fair Hearing Office.</p>			

12/17

Idaho State Veterans Home – Boise
Nursing Procedure Manual

MED A HOSPITAL NOTIFICATION

Hospital: _____

Date: _____

Reason for referral (e.g. emergency room, CT scan, outpatient surgery): _____

Resident's Name: _____ is a Medicare Part A covered patient of Idaho State Veterans Home, Boise and has been referred to your hospital outpatient department for services that may be covered by the consolidated billing provisions of the Skilled Nursing Facility Prospective Payment System (PPS).

The hospital shall bill Medicare Part B directly for any of the services listed that are excluded from the SNF consolidated billing provisions. Centers for Medicare & Medicaid Services (CMS) have identified these services by HCPCS code. Please refer to CMS annual and quarterly updates used for SNF consolidated billing at http://www.cms.hhs.gov/snfpps/05_consolidated_billing.asp

- Emergency room procedures and supplies directly related and required to complete the procedure or treat the emergency condition.
- Emergency room observation and any ancillary services provided if kept past midnight.
- End state renal disease services (free standing or hospital based).
- Erythropoietin and Aranesp for ESRD patients on dialysis.
- Physician visits – professional component including interpretation of tests.
- Psychological services – psychologist or psychiatrist.
- Chemotherapy provided for specific HCPCS codes.
- Customized prosthetics for specific HCPCS codes.

Note: the following services should also be billed by the hospital directly to Medicare Part B.

- Cardiac catheterization
- PEG tube placement
- Lymphatic procedures
- Angiography
- MRI/MRA
- Ambulatory surgery
- CT scans
- Radiation Therapy

Note: generally, ambulatory surgery codes in the range from 10040 through 69979 are excluded and billed by the hospital. However, some minor surgical codes within that range are the responsibility of the SNF. **Prior authorization must be obtained from the SNF for such services.**

Any services outside the excluded services listed above may be responsibility of the SNF, i.e. **routine or other non-emergency procedures including the technical components of diagnostic services (labs, x-ray, blood transfusion, modified barium swallow), durable medical equipment, orthotics, certain chemotherapy and radioisotope services and prosthetic devices not excluded by HCPCS codes, and other services unrelated to the visit, these services must have prior authorization from the SNF.** For those services that are the responsibility of the SNF, if authorized, the SNF will pay pursuant to Medicare's Fee Schedule related to the technical component for services.

Please contact _____, RN Manager at 208-780-1600 at the facility if there are any questions.

Sincerely, Nursing Home Administrator

12/17

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.
 1. Admission date and time will be set.
 2. 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.
 3. Admission Coordinator/Social Services will be responsible for notifying the Leadership Team, Business Office and Unit at least 48 hours prior to transfer.
 4. The Leadership Team will meet to discuss concerns and transfer protocol.
 - d. The RN Unit Manager or designee 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.
 - e. Health Information Services 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.
 - f. 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.

VAN TRANSPORTATION PROCEDURE

1. Preparing for Resident Transport:
 - a. Locate keys to the van (located in Med room on each nursing unit and in Maintenance office).
 - b. Once keys are located (depending on weather) get the van warmed up/cooled off prior to loading resident.
 - c. Consult with resident's nurse to determine if resident needs to be transported via wheelchair. If resident is in need of gurney transport, an alternate form of transport will be needed. This facility does not use gurneys.
 - d. Ensure resident is dressed appropriately for the weather and is wearing clean attire.
1. Wheelchair Transport:

THERE IS ABSOLUTELY NO ELECTRIC WHEELCHAIR ON LIFT

(Except in an emergency situation)

- a. Open side doors of transport van and lower lift to ground.
- b. Place resident on the lift with back facing the van.
- c. Lock resident's wheelchair brakes.
- d. Raise wheelchair until lift stops and is level with the platform of the van.
- e. Fasten front of wheelchair with a tie-down strap, then secure resident in wheelchair using the seat belts in the van. (If resident has a seat belt already attached to his wheelchair, still use the seatbelts located in the van.)
- f. Tie wheelchair down with four (2) straps – one on each corner of the wheelchair and then secure resident into wheelchair with a seatbelt.
- g. Secure lift inside of the van and make sure doors are shut securely.

05/06, Revised 04/08, 11/13, 04/16

VAN TRANSPORTATION TRAINING

1. Upon hire, each nursing department employee will be asked to participate in the facility's van transportation program. This program is designed to ensure safety in resident's transports by wheelchair in the facility's van(s).
2. Eligibility for participation depends on employee's driving record and other criteria, as applicable.
3. All eligible employees will receive training in van transportation techniques from an authorized facility-trained instructor.
4. Eligible employee(s) will receive training on procedure for injuries that occur during transportation on the vehicle or during transfer in/out of the facility. See procedure for **Resident Incident When Out of the Facility, Section VII-6 to VII-7**.
5. Once the employee has successfully completed the training and demonstrated competence, the instructor shall complete the "Van Transportation" form and submit this form to Human Resources to be filed in the employee's personnel file.
6. If the facility acquires new equipment or vehicle, that require additional training to ensure safe operation, then all current van drivers and newly eligible employees will receive additional training and certification of competence.

05/06, 10/15; Reviewed 11/13, Revised 04/16

Idaho State Veterans Home – Boise
Nursing Procedure Manual

IDAHO STATE VETERANS' HOME – BOISE VAN TRANSPORTATION

I certify that _____ (employee's name) has been successfully trained in the operation of the facility's transport van(s) and has demonstrated competence in their operation.

Trainer Name (please print) _____

Trainer's Signature: _____

Employee Name (please print): _____

Employee Signature: _____

Today's Date:
Date Occurred:

ADMINISTRATOR: _____

NURSING

CENSUS: 1 EAST: 1 WEST: 2 WEST: TOTAL:

PAY TYPES: MCD: MCR: PVT: SC:

ADMISSIONS	UNIT	ROOM NO.	TIME	FROM	PAY SOURCE
DISCHARGES	UNIT	ROOM NO.	TIME	TO	COMMENTS
ROOM TRANSFERS	FROM ROOM #		TO ROOM #		
BED HOLDS	UNIT	ROOM NO.	DATE	HOSPITAL	

RESIDENTIAL CARE CENSUS: 33

ADMISSIONS	ROOM NO.	TIME	FROM
DISCHARGES	ROOM NO.	TIME	TO
LEAVE/PASSES	ROOM NO.	TIME OF DEPARTURE	TIME OF RETURN
ROOM TRANSFER	FROM ROOM #		TO ROOM #

Med A Hospital Notification

Hospital: _____ Date: _____

Reason for referral (e.g. emergency room, CT scan, outpatient surgery): _____

Resident's Name: _____ is a Medicare Part A covered patient of Idaho State Veterans Home, Boise and has been referred to your hospital outpatient department for services that may be covered by the consolidated billing provisions of the Skilled Nursing Facility Prospective Payment System (PPS).

The hospital shall bill Medicare Part B directly for any of the services listed that are excluded from the SNF consolidated billing provisions. Centers for Medicare & Medicaid Services (CMS) have identified these services by HCPCS code. Please refer to CMS annual and quarterly updates used for SNF consolidated billing at http://www.cms.hhs.gov/snfpps/05_consolidated_billing.asp

- Emergency room procedures and supplies directly related and required to complete the procedure or treat the emergency condition.
- Emergency room observation and any ancillary services provided if kept past midnight.
- End state renal disease services (free standing or hospital based).
- Erythropoietin and Aranesp for ESRD patients on dialysis.
- Physician visits – professional component including interpretation of tests.
- Psychological services – psychologist or psychiatrist.
- Chemotherapy provided for specific HCPCS codes.
- Customized prosthetics for specific HCPCS codes.

Note: The following services should also be billed by the hospital directly to Medicare Part B.

- Cardiac catheterization
- PEG tube placement
- Lymphatic procedures
- Angiography
- MRI/MRA
- Ambulatory surgery
- CT scans
- Radiation Therapy

Note: generally, ambulatory surgery codes in the range from 10040 through 69979 are excluded and billed by the hospital. However, some minor surgical codes within that range are the responsibility of the SNF. **Prior authorization must be obtained from the SNF for such services.**

Any services outside the excluded services listed above may be responsibility of the SNF, i.e. **routine or other non-emergency procedures including the technical components of diagnostic services (labs, x-ray, blood transfusion, modified barium swallow), durable medical equipment, orthotics, certain chemotherapy and radioisotope services and prosthetic devices not excluded by HCPCS codes, and other services unrelated to the visit, these services must have prior authorization from the SNF.** For those services that are the responsibility of the SNF, if authorized, the SNF will pay pursuant to Medicare's Fee Schedule related to the technical component for services.

Please contact _____, RN Manager at 208-780-1600 at the facility if there are any questions.

Sincerely,

Nursing Home Administrator

12/17

**IDAHO STATE VETERANS HOME - BOISE
MIDNIGHT CENSUS REPORT**

Date: _____

SKILLED NURSING CENSUS _____

ADMISSIONS

Residents Name	Admitted From	Time	Room/bed

DISCHARGES

Resident Name	Discharged To	Time

ROOM/BED TRANSFERS

Resident Name	From Room/Bed	To Room/Bed

LEAVES/PASSES

Resident Name	To	Time	Date Returned	Time

Hospital Leave/Return (only if gone less than 24 hours)

Resident Name	Hospital	Time Left	Time Return

Notice of Resident Transfer

Date of Notice:
Name: Idaho State Veterans Home - Boise

Address: 320 Collins Road	City: Boise	State: Idaho	Zip: 83702
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As per the admission agreement, the facility must transfer a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services. This notice is to inform you that (Resident Name) _____

Will be transferred to (location) _____ for the following reason(s):

- The transfer is necessary for the resident's welfare and the resident's needs cannot be met in this facility.
- The safety of individuals in the facility is endangered by the resident being here.
- The health of individual is endangered.
- Therapeutic leave has been scheduled from (date) _____ to (date) _____.

The decision to transfer was discussed and agreed to by the resident's physician.

Staff Signature/Title: _____ Date: _____

Involuntary Discharges and Appeal Rights

In the event it has been determined that you cannot return to the facility a Notice of Discharge will be provided to you or your representative and the Office of the State Ombudsman. Residents have the right to appeal to the state the facility's decision to involuntary discharge. A written notice, regarding the circumstances of involuntary discharge, will be made by the facility pursuant to federal and state requirements. Notices concerning involuntary discharges will contain the resident's right to request a fair hearing through the Idaho Department of Health and Welfare, Fair Hearing Office.

Idaho State Veterans Home – Boise
Nursing Procedure Manual

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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:
 1. A resident-to-resident altercation
 2. A recent fall
 3. 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 on the "Precaution – Observation Form."
2. The Licensed nurses assigned to the resident will be responsible for ensuring completion of the form.
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 > 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.
5. Once the observation is finished, the completed form shall be routed to the Unit RN Manager for review and disposition.

6/06, 7/09, 12/16 Reviewed 11/13

Idaho State Veterans Home – Boise
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PRECAUTION – OBSERVATION FORM
(Initial Q 15 minutes – 24 hrs. QD)

PLEASE INDICATE LOCATION OF RESIDENT FROM THE KEY (bottom of page) AT SPECIFIED TIME.
PLACE NUMBER IN LOCATION BOX AND INITIAL.

TIME	LOCATION	INITIALS	TIME	LOCATION	INITIALS	TIME	LOCATION	INITIALS
0600			1400			2200		
0615			1415			2215		
0630			1430			2230		
0645			1445			2245		
0700			1500			2300		
0715			1515			2315		
0730			1530			2330		
0745			1545			2345		
0800			1600			2400		
0815			1615			0015		
0830			1630			0030		
0845			1645			0045		
0900			1700			0100		
0915			1715			0115		
0930			1730			0130		
0945			1745			0145		
1000			1800			0200		
1015			1815			0215		
1030			1830			0230		
1045			1845			0245		
1100			1900			0300		
1115			1915			0315		
1130			1930			0330		
1145			1945			0345		
1200			2000			0400		
1215			2015			0415		
1230			2030			0430		
1245			2045			0445		
1300			2100			0500		
1315			2115			0515		
1330			2130			0530		
1345			2145			0545		

LOCATION KEY: 1=Bed 2=Dining Room 3=Activities 4=Bathroom
5=Hall 6 = Common Area (TV Room)

RESIDENT: _____ ROOM: _____

DATE: _____

Revised 04/2020

BLADDER ASSESSMENT AND INCONTINENCE MANAGEMENT

Purpose

Residents will be assessed for bladder continence and provided appropriate treatment to achieve or maintain as much normal urinary function as possible.

Procedure

1. Resident's bladder function will be assessed on admission, following administration of antibiotics for a urinary tract infection, following the removal of an indwelling urinary catheter and whenever there is a change in the resident's urinary function.
2. BVH Bladder Incontinence Assessment will be the instrument used for the assessment.
3. Based on the results of the assessment further interventions may occur such as:
 - a. Resident will participate in an individualized toileting program.
 - b. Resident will participate in an individualized bladder retraining program.
4. The Bladder Program Nurse will be responsible for initiating the appropriate bladder program.

Forms Completion

1. BVH Bladder Incontinence Assessment

- a. Bladder Program Nurse or their designee will complete the Current Resident Status section in Point Click Care (PCC) Assmts tab.
- b. Bladder Program Nurse or their designee will complete the Bladder Status section based on information gained from the resident's voiding activities (evaluated over a 3-day period) and other physical and environmental information in Point Click Care (PCC) Assmts tab.

Note: The facility shall implement a process to evaluate the resident's urinary voiding pattern using the **Bladder Data Collection** sheet. This information will typically be gathered during a 3- day period. Several items related to the resident's voiding will be evaluated and this information will be provided to the Bladder Program Nurse or designee for use in establishing the most appropriate toileting/bladder retraining interventions.

2. **The Bladder Data Collection** sheet will be implemented to assist staff in determining most appropriate toileting/retraining program and to assist in the completion of the Bladder Incontinence Assessment.
 - a. The Bladder Data Collection sheet will be kept at the nurse's cart and typically this information is gathered for a period of 3 days.
 - b. Bladder scans may be conducted in association with the data collection. Typically bladder scans will be implemented if the resident has a diagnosis of diabetes, prostate disorders, neurologic conditions such as post-acute stroke, multiple sclerosis, spinal cord injury, history of urinary retention. If any of these diagnoses

are present then the resident shall have a bladder scan conducted typically after voiding (PVR) to determine if the bladder has completely emptied.

- c. ~~Results of the bladder scans will be documented in the resident's MAR.~~ Bladder data will be documented on the 3-day voiding collection sheet.

3. Candidate for Bladder Retraining

- d. The Bladder Program Nurse will complete this section and based on the score a decision will be made whether to proceed with bladder retraining or refer the resident for evaluation in a toileting program.
- e. The Bladder Program Nurse will prioritize those residents who are eligible for bladder retaining. In order to ensure successful retraining no more than 3 residents will be involved in the retraining program at any one time.

4. Care Plan – Temporary – Bladder Retraining

- a. Based on the retraining data, the Bladder Program Nurse will implement the appropriate care plan interventions.
- b. These interventions will be communicated to facility staff.

3/06, 6/06, 8/07, 08/14, 12/15

Idaho State Veterans Home – Boise
Nursing Procedure Manual

BLADDER DATA COLLECTION, 3-DAY VOID PATTERN

Resident's Name _____ Date _____

Day 1					Day 2					Day 3				
Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comments	Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comment	Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comments
7:00 am		Yes/no	S/M/L		7:00 am		Yes/no	S/M/L		7:00 am		Yes/no	S/M/L	
8:00 am		Yes/no	S/M/L		8:00 am		Yes/no	S/M/L		8:00 am		Yes/no	S/M/L	
9:00 am		Yes/no	S/M/L		9:00 am		Yes/no	S/M/L		9:00 am		Yes/no	S/M/L	
10:00 am		Yes/no	S/M/L		10:00 am		Yes/no	S/M/L		10:00 am		Yes/no	S/M/L	
11:00 am		Yes/no	S/M/L		11:00 am		Yes/no	S/M/L		11:00 am		Yes/no	S/M/L	
Noon		Yes/no	S/M/L		Noon		Yes/no	S/M/L		Noon		Yes/no	S/M/L	
1:00 pm		Yes/no	S/M/L		1:00 pm		Yes/no	S/M/L		1:00 pm		Yes/no	S/M/L	
2:00 pm		Yes/no	S/M/L		2:00 pm		Yes/no	S/M/L		2:00 pm		Yes/no	S/M/L	
3:00 pm		Yes/no	S/M/L		3:00 pm		Yes/no	S/M/L		3:00 pm		Yes/no	S/M/L	
4:00 pm		Yes/no	S/M/L		4:00 pm		Yes/no	S/M/L		4:00 pm		Yes/no	S/M/L	
5:00 pm		Yes/no	S/M/L		5:00 pm		Yes/no	S/M/L		5:00 pm		Yes/no	S/M/L	
6:00 pm		Yes/no	S/M/L		6:00 pm		Yes/no	S/M/L		6:00 pm		Yes/no	S/M/L	
7:00 pm		Yes/no	S/M/L		7:00 pm		Yes/no	S/M/L		7:00 pm		Yes/no	S/M/L	
8:00 pm		Yes/no	S/M/L		8:00 pm		Yes/no	S/M/L		8:00 pm		Yes/no	S/M/L	
9:00 pm		Yes/no	S/M/L		9:00 pm		Yes/no	S/M/L		9:00 pm		Yes/no	S/M/L	
10:00 pm		Yes/no	S/M/L		10:00 pm		Yes/no	S/M/L		10:00 pm		Yes/no	S/M/L	
11:00 pm		Yes/no	S/M/L		11:00 pm		Yes/no	S/M/L		11:00 pm		Yes/no	S/M/L	
Midnight		Yes/no	S/M/L		Midnight		Yes/no	S/M/L		Midnight		Yes/no	S/M/L	
1:00 am		Yes/no	S/M/L		1:00 am		Yes/no	S/M/L		1:00 am		Yes/no	S/M/L	
2:00 am		Yes/no	S/M/L		2:00 am		Yes/no	S/M/L		2:00 am		Yes/no	S/M/L	
3:00 am		Yes/no	S/M/L		3:00 am		Yes/no	S/M/L		3:00 am		Yes/no	S/M/L	
4:00 am		Yes/no	S/M/L		4:00 am		Yes/no	S/M/L		4:00 am		Yes/no	S/M/L	
5:00 am		Yes/no	S/M/L		5:00 am		Yes/no	S/M/L		5:00 am		Yes/no	S/M/L	
6:00 am		Yes/no	S/M/L		6:00 am		Yes/no	S/M/L		6:00 am		Yes/no	S/M/L	

Product Worn (circle item): **Pad, Panty liner, Brief** Other (specify) _____ (*) **S** = Slightly Wet **M** = Wets Most of Pad **L** = Outside of Clothing is Wet

Reviewed by: _____

Physician Review: _____

ASSESSMENT & COMMUNICATION GUIDELINES USING SBAR FORM

Guidelines for Communicating with Physicians Using the **S** (Situation) **B** (Background)
A(Assessment) **R** (Recommendation) process:

1. Prior to calling the physician, please ensure the following:
 - a. The specific resident was seen and assessed by the licensed nurse placing the call.
 - b. Admitting diagnosis and date of admission are readily available.
 - c. The licensed nurse has read the most recent MD progress notes and the nurses' notes.
2. Have the following information available when speaking with the physician:
 - d. Resident's chart
 - e. List of current medications, allergies, IV fluids, and labs
 - f. Most recent vital signs
 - g. Code status
 - h. If reporting lab results provide the date and time test was done and results of previous tests for comparison.
3. When calling the physician, follow the SBAR process:

SITUATION

I am calling about <resident name and unit/room #>

The resident's code status is <code status>

I have just assessed the resident personally:

Vital signs are: Blood pressure_____/_____, Pulse____Respiration___Temp

I am concerned about the resident's:

Blood pressure because it is (over 200 or less than 100 or 30 mmHg below usual)

Pulse because it is over 140 or less than 50

Respiration because it is less than 5 or over 40

Temperature because it is less than 96 or over 104.

Or, the resident's vital signs are within normal limits for him/her.

BACKGROUND

The resident's mental status is:

Alert and oriented to person, place and time

Confused and cooperative or non-cooperative

Agitated or combative

Lethargic but conversant and able to swallow

Stuporous and not talking clearly and possibly not able to swallow

Comatose. Eyes closed. Not responding to stimulation

The resident's skin is:

Warm and dry

Pale

Mottled

Diaphoretic Extremities are cold

Extremities are warm

The resident is not or is on oxygen:

The resident has been on _____ (l/min)

The resident's O2 Saturation reading is _____ %

ASSESSMENT

This is what I think the problem is: <say what you think the problem is>

The problem seems to be: cardiac ___ infection ___ neurologic ___ respiratory ___
other

Or

I am not sure what the problem is but the resident is deteriorating.

The resident seems to be unstable and may get worse, we need to do something.

RECOMMENDATION

I suggest or request that you <say what you would like to see done>

Transfer the resident to an acute care hospital

Ask for a consultant or other physician to see the resident

Other

Are any tests needed?

If a change in treatment or medication is ordered, then ask:

How often do you want vital signs?

How long do you expect the problem to last?

If the resident does not get better when would you like us to call you again?

4. The above information/format should also be utilized when transferring a resident to another facility (e.g. ER) who is experiencing an acute illness or urgent situation.
5. Include in your information to the other facility the resident's family/responsible party who was notified and any other pertinent information, e.g., they will be coming to the ER, do not call them with updates, etc.
6. System review (as applicable) – incorporate applicable system into the **SBAR** process using the following as guides to the background/assessment/recommendation.

a. Respiratory

1. Lung sounds – abnormal lung sounds and location
2. Nature of respirations – depth and rate, use of accessory muscles, sounds audible without stethoscope, dyspnea on exertion and/or at rest
3. Cough – productive or nonproductive, congested or dry, frequency, description of any sputum (color, consistency, amount)
4. Hydration – amount of fluid intake, encouragement needed to take fluids
5. Pain – description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity

b. Cardiovascular

1. Pain – description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
2. Edema – site, pitting or non-pitting
3. Heart sounds – rate and rhythm
4. Resident symptoms – syncope, fainting, flutters, other sensations in chest
5. Lung sounds – abnormal sounds and location
6. Respirations – depth & rate, use of accessory muscles, dyspnea on exertion and/or at rest
7. Cough – productive or nonproductive, congested or dry, frequency, description of any sputum (color, consistency, amount)
8. Medications administered – e.g. nitrostat – results

c. Gastro-intestinal

1. Nausea/vomiting – frequency, description of emesis (amount, color, consistency)
2. Diarrhea – frequency, description of stool (amount, color, consistency)
2. Medications administered – e.g. MOM, Mylanta – results
3. Pain – description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
4. Turgor evaluation – mucosa, skin

5. Skin assessment – dry, cool, clammy, pale

d. Genito-urinary

1. Pain – description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
2. Urinary frequency/urgency
3. Change in urinary continence
4. Fluid intake versus output
5. Urine – color, odor, sediment

e. Central Nervous System

1. Change in functional status – weakness, paralysis, spasticity, flaccidity – description – define extremity(ies) affected
2. Aphasia – if present – degree of impairment, expressive or receptive or both
3. Swallowing – if affected – food or fluid consistency impacted
4. Responsiveness – any changes – describe response to pain, eyes open or closed, restlessness, etc.

f. Musculo-skeletal

1. Pain – description of pain (aching, stabbing, throbbing, burning), location, constant/intermittent, severity.
2. Change in level of activity/mobility
3. Change in alignment – hip/leg, shoulder/arm
4. Pain medication administered – results
5. History of falls
6. Diagnosis impacting musculo-skeletal function

Revised 09/08, Reviewed 11/13, 03/16

ASSESSMENT & COMMUNICATION GUIDELINES USING SBAR SITUATION

I am calling about <resident name and unit/room #>

The resident's code status is <code status>

I have just assessed the resident personally:

Vital signs are: BP_____/_____, Pulse_____, Respiration____and temperature

I am concerned about the:

Blood pressure because it is (over 200 or less than 100 or 30 mmHg below usual)

Pulse because it is over 140 or less than 50

Respiration because it is less than 5 or over 40

Temperature because it is less than 96 or over 104.

Or, the resident's vital signs are within normal limits for him/her.

BACKGROUND

The resident's mental status is:

Alert and oriented to person, place and time

Confused and cooperative or non-cooperative

Agitated or combative

Lethargic but conversant and able to swallow

Stuporous and not talking clearly and possibly not able to swallow

Comatose. Eyes closed. Not responding to stimulation

The skin is:

Warm and dry - Pale – Mottled – Diaphoretic - Extremities are cold - Extremities are warm

The resident is not or is on oxygen:

The resident has been on____(l/min) - The resident's O2 Saturation reading is_____%

ASSESSMENT

This is what I think the problem is: <say what you think the problem is>

The problem seems to be: cardiac infection neurologic respiratory other

or _____

I am not sure what the problem is but the resident is deteriorating.

The resident seems to be unstable and my get worse, we need to do something.

RECOMMENDATION

I suggest or request that you <say what you would like to see done>

Transfer the resident to an acute care hospital

Ask for a consultant or other physician to see the resident

Other

Are any tests needed?

If a change in treatment or medication is ordered then ask:

How often do you want vital signs?

How long do you expect the problem to last?

If the resident does not get better when would you like us to call you again?

Reviewed 11/13

DENTAL SERVICES / ASSESSMENT

1. All residents will be evaluated for the need for dental services upon admission and at least annually thereafter.
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 VAMC or 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 resident loses or chooses not to wear dentures, assessment to be completed to ensure correct diet texture and document in PCC.
5. If a resident refuses treatment, it is noted in the medical record by the medical provider or licensed nurse.
6. Dentures shall be labeled by the unit Senior Certified Nursing Assistant or designee.
7. The resident's care plan shall be updated by the RN Unit Manager or designee as applicable.

Reviewed 11/13, Revised 04/2020

FALL RISK EVALUATION

Procedure

1. Residents admitted into the Idaho State Veterans Home - Boise will have a complete BVH Fall Risk Evaluation completed by licensed nursing staff.
2. The BVH Fall Risk Evaluation will be completed in the resident's medical record in Point Click Care (PCC) Assmnts tab.
3. A quarterly BVH Fall Risk Evaluation will be completed thereafter by the Unit RN Manager (or designee). This assessment will coincide with the resident's RAI schedule.
4. The BVH Fall Risk Evaluation 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 three {3} months)
 - c. Ambulation/elimination status.
 - d. Vision status
 - e. Gait/balance
 - f. Systolic blood pressure
 - g. Medications
 - h. Predisposing diseases
5. Upon completion of the BVH Fall Risk Evaluation, the nurse completing the form will sign and lock the assessment in PCC.

Falls scoring guidelines for suggested care plan interventions are 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 i.e.: proper w/c if applicable, padding on floor, etc.
 - e. Q 1- hour check when not in highly visible area for safety and needs i.e.: physical needs such as toileting.
3. Score of 10 or more = High Falls Risk Category
 - a. All interventions listed above for Medium Falls Risk
 - b. Position resident near nurses' station when not in bed or involved in an activity.
 - c. 30- minute checks when in bed
 - d. Assess need for modified environment (padding on floor, wheels off bed, etc.).
 - e. Referral to PT/OT for screen as indicated.

02/01, revised 03/02, 10/03, 02/13, 09/14, 04/2020; Reviewed 11/13

HEARING SERVICES / ASSESSMENT

1. All residents will be evaluated for the need of hearing/audiology services upon admission and at least annually thereafter.
2. Before an audiology consult is ordered, ears of residents shall be checked with an otoscope to ensure no wax is blocking ear canals.
3. If the resident has intact eardrums and wax is currently in the ear, then the resident's physician shall order ear irrigation as appropriate and, a subsequent hearing exam as appropriate.
4. Request for hearing/audiological services shall be ordered by the resident's physician and the facility shall make arrangements for hearing/audiological services through either the VAMC or the resident's preferred provider.
5. The resident's physician (or designee) shall conduct a hearing assessment.
 - a. If applicable, ensure resident has operable hearing aids in place.
 - b. Interview resident and ask about hearing function.
 - c. Observe resident.

11/03, 04/2020; Reviewed 11/13

ASSESSMENT OF FACTORS IMPACTING INSOMNIA

Most cases of insomnia are associated with underlying conditions (secondary or co-morbid insomnia) such as psychiatric disorders (e.g. depression), cardiopulmonary disorders (e.g. COPD, CHF), urinary frequency, pain, obstructive sleep apnea, and restless leg syndrome.

1. **Before** initiating medications to treat insomnia factors which have the potential to cause insomnia will be evaluated.
 - a. Resident's environment exposes resident to excessive heat, cold or noise.
 - b. Resident's environment exposes resident to lighting that is too bright or too dim to conduct activities of daily living or sleep.
 - c. Resident does not receive adequate physical activity or environmental stimuli.
 - d. The facility routines such as time to sleep, awakening, toileting, medication/treatments, and meals do not accommodate resident needs.
 - e. Direct care of either resident or his/her roommate(s) disrupts the resident's sleep.
 - f. Resident consumes caffeine or medications that are known to disrupt sleep, prior to attempting to sleep.
 - g. Resident is experiencing pain or discomfort.
 - h. Resident has existing diagnoses and/or conditions that may cause insomnia such as depression, cardio pulmonary disorders (e.g. CHF, COPD), urinary frequency, pain, obstructive sleep apnea and/or restless leg syndrome. Physician to evaluate extent of above for possible impact on resident's sleep pattern.
 - i. Other factors that may negatively impact resident's ability to sleep.
2. Complete Insomnia Assessment in PCC.
3. The results of this evaluation will be communicated to the resident's primary physician prior to obtaining an order for a sleep-inducing medication (either scheduled or PRN). e.g. Trazadone. (Exceptions will be a resident who comes into the facility with an order for medication to treat insomnia.)

2/07, Revised 2/08, 09/14, 04/2020; Reviewed 11/13

MINIMUM DATA SET (MDS) POLICY AND PROCEDURE

Standard

A nursing assessment, the first step in the nursing process, is completed on each new admission, quarterly, annually, and when a change in condition occurs.

Policy

The Minimum Data Set (MDS) Form records information obtained during the nursing assessment. The facility will use the State-specified RAI.

The MDS form becomes a permanent part of the medical record.

Procedure

1. The Nurse initiates a nursing assessment on newly admitted residents that occurred during his/her shift.
2. The MDS Form is used as a baseline for information for initiation of the Resident Care Plan.
3. All Resident Assessment Instruments (RAI's), the MDS Forms, Care Area Triggers and Care Area Assessment (CAA) must be completed within 14 days of admission. Exceptions will be those residents admitted under Medicare A status. This will also exclude readmissions in which there is no significant change in the resident physical or mental condition. (Readmission means a return to the facility following a temporary absence for hospitalization or for therapeutic leave).
4. A quarterly assessment is completed within 92 days of the previous assessment.
5. An annual comprehensive assessment is completed within 366 days after completion of the most recent comprehensive resident assessment.
6. RNM to notify MDS of potential change of condition and then the MDS Coordinator will notify the interdisciplinary team if need for significant change of condition is noted and will instruct the individual team members to start the MDS assessments. The MDS Coordinator will use the RAI Manual as a guide to determine if "Change of Condition" has occurred. The Comprehensive assessment will be completed within 14 days after determination of significant change of condition.
- ~~7. The facility will retain **the current** resident assessments in the resident's **active** record starting with the admission assessment. **the previous 15 months MDS records, if applicable, are located in overflow at each nursing station, and in EMR for assessments completed after 9/1/2013.**~~
8. The MDS Coordinator or designee is responsible for transmission of the MDS within the required timelines.

Revised 01/08, 09/10, 11/13, 10/19

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 on 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 Instruction Manual. All team members need to have access to 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:
 1. Condition will not normally resolve itself without further interventions, is not "self-limiting" (for declines only).
 2. Condition impacts more than one area of resident's health status (Refer to RAI manual that will give more specific information.); and
 3. 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 and discharge tracking records will be completed by the MDS coordinator.

4. DISCIPLINES' RESPONSIBILITIES FOR RAI PROCESS

- a. Each discipline will be assigned the following sections:

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- 1). Nursing: A0050-A0410, A1600-A2400, B0100-B1200, G0110-G0120, G0600-G0900, H0100-H0600, I0100-I08000, J0100-J1900, L0200, M0100-M1200, N0300-N0410, O0100-O0300, O0400D-F, O0450, O0600-O0700, P0100, V0100A-C, V 0200 B-C, Z 0100 – Z 0500, X0150-X1100 PRN
- 2). Social Services: A0500-A1550, C0100-C1600, D0100-D0650, E0100-E1100, Q0100- Q0600, V0100D-F
- 3). Dietary: K0100-K0710
- 4)Activities: F0300-F0800
- 5). Therapy: O0400A-C, O0420
- 6). Restorative: G0300- G0400, O0500

- 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:

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

Social Services:

- # 1 – Delirium
- # 2 – Cognitive loss
- # 7 – Psychosocial well-being
- # 8 – Mood State

Idaho State Veterans Home – Boise
Nursing Procedure Manual

9 – Behavior

20 – Return to Community Referral

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 Managers/MDS Coordinators to be completed by LNs during the 7-day observation period for MDSs.
- b. Restorative will complete and submit Balance During Transitions & Walking & Functional Limitation in ROM Assessment that will be reviewed by the Restorative Nurse and co-signed.
- c. Therapy will complete and submit for section O0400 A-C, O0410 number minutes/days of ST, OT, and PT on the therapy form and give to MDS Coordinator/MDS Nurse, and section O0410.

03/03, revised 12/03, 01/08, 09/10, 03/12, 06/12, 11/13

NEUROLOGICAL CHECKLIST

When a resident experiences a change in the level of consciousness, an unwitnessed fall and/or a fall involving possible injury to the head the following procedure will be implemented:

After initial assessment:

1. Transport resident as deemed appropriate by a licensed nurse, in collaboration with the physician:
2. Institute neurological assessments using the Neurological Checklist per the following schedule: (to be completed by a licensed nurse)
 1. Assessments q 15 minutes x 4, then:
 2. Assessments q 30 minutes x 2, then:
 3. Assessments q 1hour x 2, then:
 4. Once per shift x 72 hours
- ~~3. Total assessment time should continue for approximately 76 hours.~~
4. If the resident is unavailable (eating, attending an activity, at a medical appointment, etc.) when the neuro check is scheduled; complete the assessment as soon as the resident is available. Document in nurses notes why assessment was late. It is expected the resident will be woken if sleeping and an assessment completed.
5. Assessment should include vital signs until all Assessments are complete.
6. Completed Checklist should be given to the RN Manager.

Revised 01/02, Reviewed 11/13, Revised 01/16, 04/16, 10/19

NEUROLOGICAL CHECKLIST FORM

Neurological Checklist (FRONT)

This checklist should be completed at the following intervals for follow up for all unwitnessed falls or falls in which head is struck. Any change in resident condition requires a phone call to the primary care physician.

- Initial assessment followed by q15 min x 4, q30 min x 2
- Every hour x 2
- Once per shift for 72 hours (9 shifts, D=day, E=evening, N=night)

Resident name: _____ Room #: _____

Physician: _____ Medical record #: _____

Description	B*	q15 x 4				q30 x 2				q1 x 2				Every shift X 72 hours (9 shifts D, E, N)			
Date																	
Time or shift																	
Vital Signs																	
Assess blood pressure for increase or decrease. Assess pulse for slowing or widening pulse, then increase rate. Assess respirations for change in rate, rhythm, pattern, and rate of expiration.																	
Blood Pressure																	
Pulse																	
Respirations																	
Orientation (write "check mark (✓)" for yes and "(0)" for no)																	
Place																	
Person																	
Date/Time																	
Eye Responses: A. Eyelid Movement																	
4 = Opens eyes spontaneously and purposely 3 = Opens eyes only in response to speech ("Please open your eyes.") 2 = Opens eyes in response to pain (apply blunt pressure with an object such as a pencil to the fingernail where it enters the skin of the finger) 1 = Does not open eyes when painfully stimulated U= Untestable																	
Eye Score																	

(see back to complete form)

Idaho State Veterans Home – Boise
Nursing Procedure Manual

Falls: Neurological Checklist (back)

Description	B*	q15 x 4				q30 x 2				q1 x 2				Every shift X 72 hours (9 shifts D, E, N)				Daily
Eye Response: B. Pupil																		
(+) = Reactive (-) = Non-reactive (c) = cannot cooperate In Millimeters																		
Right size																		
Right reaction																		
Left size																		
Left reaction																		
Hands, Right/Left: Check if right and left responses are the same.																		
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																		
Right hand																		
Left hand																		
Arms, Right/Left: Check if right and left responses are the same. It is necessary to know the resident's baseline ability for arm and leg strength.																		
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																		
Right arm																		
Left arm																		
Legs, Right/Left: Check if right and left responses are the same. It is necessary to know the resident's baseline ability for arm and leg strength.																		
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																		
Right leg																		
Left leg																		
Notifications: Yes or N/A (Document time, name, outcome in Nurse's Notes)																		
Physician notified if change in status																		
Family notified if change in status																		
Nurse's Initials																		

*B = Baseline (this is 1st set of vitals and neuro following fall)

Document available at www.primaris.org

MO-06-43-0027 July 2008 This material was prepared by Primaris, the Medicare Quality Improvement Organization for Missouri, under contract with the Centers for Medicare & Medicaid Service (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.



Added 04/16

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, quarterly and as identified appropriate such as in the event of a change in the resident's pain med regimen and/or frequency, severity of pain using the BVH Pain Assessment in Point Click Care (PCC) Assmnts tab.
 - 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. The use of as needed (PRN) medications for this type of pain is inappropriate.
 - d. Medication for breakthrough pain is often necessary when treating chronic pain.
 - e. Residents receiving narcotic analgesics sometimes become tolerate 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.
2. Process:
 - a. Perform a pain assessment utilizing/completing the BVH Pain Assessment in Point Click Care (PCC) Assmnts tab.
 1. Whenever possible, obtain all information directly from the resident. When the resident is unable to participate, obtain information from caregivers and family members.
 2. In some cases, use behavioral cues to gather information.

- b. Review the resident's current pain medication regimen to determine the following:
 1. Name of drug, dose, and frequency ordered.
 2. How long the resident has been on this medication.
 3. Degree of relief experience from this medication.
3. Managing Pain:
 - a. In treating pain, the following is recommended:
 1. For mild pain, may use any or all of the following: quiet, dimly lit room; repositioning; relaxation in bed or a comfortable chair; or distraction by using music, TV, bingo, or other activities preferred by resident. If no relief, give Acetaminophen (Tylenol) or nonsteroidal anti-inflammatory drug (NSAID) or other analgesic as ordered by the physician. The non-pharmacological measures above and the medications listed can be used together.
 2. For moderate pain, the use of a medication containing codeine (Acetaminophen with codeine), oxycodone, OxyContin, or hydrocodone w/APAP is recommended or an analgesic as ordered by the physician. The relaxation and distraction techniques described above should also be used, either alone or in conjunction with medication.
 3. For severe pain, the use of an opioid narcotic is recommended, such as morphine or duragesic patch or an analgesic as ordered by the physician. The use of meperidine (Demerol) to treat severe chronic pain is not recommended, but this drug can be used to treat acute short-term pain. Distraction and relaxation techniques may be used to help enhance the use of the opioid narcotics.
 4. For pain related to degenerative joint disease (e.g., arthritis), medications listed under mild pain are almost always used rather than narcotics. Positioning, relaxation, and distraction techniques are particularly important in this population. The use of ice or heat as ordered by the physician can also be used for pain relief.
 - b. If resident receives a regularly scheduled pain medication, then pain shall be assessed a minimum of every shift and interventions implemented as appropriate.
 - c. When treating pain, start with a drug appropriate to the resident's current level of pain.
 - d. 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.
 - e. 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.
 - f. Monitor to ensure that total dosages (regularly scheduled + PRN) do not exceed allowable daily dosages. (e.g., Acetaminophen should not exceed 9 {325mg.} tabs (or 3000 mg) in 24- hour period.)

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- g. 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)
 - h. Assess and document pain using an appropriate pain scale prior to and after administration of PRN analgesics. Document on eMAR.
 - 1. Document level of pain: Level 0-10. If resident unable to verbalize, then evaluate pain relief using observable/behavioral pain cues.
 - 2. Document source of pain, reason for administering pain medication and /or other pertinent information on eMAR.
 - 3. 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.
 - i. 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 intolerable, then the attending physician or unit RN Manager shall be notified.
 - j. Management of the side effects of analgesics is the joint responsibility of the attending physician and the nursing staff.
4. MDS Process:
- a. Residents will be assessed for pain per MDS guidelines and coded appropriately on the MDS.
 - b. If a resident is coded on the MDS for moderate pain and there is a change in pain severity, then the RNM shall be notified.
5. Resident Care Plan:
- a. The resident care plan is updated as needed. Documentation in the nurse progress notes is done according to protocol.

3/01, revised 02/06, 06/06, 06/08, 07/08, 01/09, 2/10, 09/14, 11/14, 04/2020

PRN PSYCHOTROPIC MEDICATION ASSESSMENT

Procedure

1. 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.
 - a. The nurse will complete the BVH PRN PSYCHOTROPIC/HYPNOTIC/ANTI-ANXIETY MEDICATION ASSESSMENT in Point Click Care (PCC) under Assmnts tab and based on the responses, intervene as appropriate.
 - b. The RN Unit Manager will be notified of the use of the PRN psychotropic medication by the nurse that completed the assessment.

02/06, revised 08/06, 03/13, 09/14

SEIZURE EVALUATION

1. Licensed nursing staff will utilize the Seizure Evaluation Worksheet to assist in accurately assessing a resident's seizure activity.
2. Licensed nursing staff shall complete the worksheet following evaluation of the seizure to help ensure that the seizure was completely and accurately assessed.
3. Information obtained through completion of the worksheet shall be communicated to the resident's primary physician and a summary of the seizure activity will be documented in the nurse progress note section of the resident's medical record.
4. The worksheet shall not be retained as part of the medical record but simply serves as a guide to the licensed nurse during the assessment process.
5. The worksheet should be disposed of following each use.

5/02, Reviewed 11/13

SEIZURE EVALUATION WORKSHEET

Resident's Name _____ Room _____ Date _____
Time _____ Duration of Seizure (approx.) _____

INITIATE NEURO WORKSHEET

SEIZURE (HARD – MAJOR) – Check all that apply:

- Eyes Turn_Right Side_Left Side
- Twitching of face Right Side_Left Side
- Difficulty breathing_Before_During_After
- Color changes of skin, lips and/or nail beds
- Sudden loss of consciousness
- Falls to ground or floor
- Body rigid with general trembling of extremities
- Extremities thrash violently: _R Arm_L Arm_R Leg_L Leg
- Tongue biting
- Loss of bladder control
- Frothing at the mouth
- After seizure, falls into deep sleep
- After seizure, confused or disoriented

SEIZURE (LIGHT – MINOR) – Check all that apply:

- Head falls forward abruptly
- Drops to floor and up quickly
- Unconsciousness only momentarily
- Blinking or fluttering of eyelids
- Blank Stare
- Slight turning of eyes
- Momentarily stiffening of extremities

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Additional Comments:

The above information is designed to assist staff in evaluating a resident's seizure activity – information should be used to help formulate documentation into nurse progress notes and assist in communicating seizure information to physician.

**THIS WORKSHEET SHOULD NOT BE PLACED IN THE RESIDENT'S
MEDICAL RECORD.**

05/02, Revised 02/03

SELF-ADMINISTRATION OF MEDICATION

Procedure

Residents who have been assessed to be cognitively and physically capable of participating in self-administration of medications shall be assisted in the following manner.

1. Order for participation in self-administration of medications shall be obtained from physician.
2. Medications shall be prepared by the pharmacist according to guidelines listed in IDAPA 16.03.02.201.02.I (labeling, dosage, etc.)
3. Medications dispensed to residents for self-administration shall be limited to two units of dosage with the exception of medications that are only packaged in multi-dose units (e.g. artificial tears, inhalers, nasal sprays). The resident must be able to demonstrate that he is capable of safely administering medications of the multi-dose unit and reporting each use to the nurse on the unit.
4. The resident must be educated by the pharmacist/licensed nurse regarding proper time, route, and side effects of the medications to be used. The resident should be able to repeat this information to the pharmacist, nursing staff, and physician and be able to demonstrate proper administration techniques to those monitoring the self-administration program.
5. Medications to be administered in the self-administration program must be kept in a locked drawer at the individual resident's bedside.
6. The licensed nurse assigned to a resident on a self-administration program shall check the inventory of the medications kept at the bedside and document the use of the medications on the resident's eMAR on a shift/daily basis.
7. The resident's participation in the self-administration program shall be listed on the care plan with reference to the self-administration program/procedure.
8. In the event the resident's physician orders self-administration medications, the resident's ability to self-medicate will be assessed utilizing the BVH Self-Medication Assessment in Point Click Care (PCC) Assmnts tab. (Include those residents using hand-held nebulizers.)
9. For those residents using hand-held nebulizers/**MDI**, the nurse will maintain nebulizer/**MDI** medications at the med cart so items #1-6 do not apply. Care plan does need to address resident's ability to self-administer nebulizer medications.
10. The resident shall be subsequently assessed per focus charting guidelines (MDS schedule) for his/her ability to continue with participation in the program utilizing the BVH Quarterly Self-Administration of Medications Assessment.
11. For the purpose of this policy, over the counter medications will be treated in the same manner as prescription medication.

11/00 Revised 03/02, 04/07, 01/09, 4/09, 09/14, 11/14, 10/19; Reviewed 11/13

TURNING BARS/SIDE RAIL ASSESSMENT

Purpose

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

Procedure

1. Upon admission, and in the event side rails are added/removed or there is a change in the bed's components, a resident will be evaluated for use of bedside rail(s) using the BVH Side Rail Assessment. The assessment will be completed in the resident's medical record in Point Click Care (PCC) Assmnts tab.
2. Subsequent assessments will be conducted per focus charting guidelines (MDS schedule, Quarterly, PRN) utilizing the BVH ~~Quarterly~~ Side Rail Assessment.
3. Results of the assessment will be care planned and physician orders written (as appropriate).
4. Residents using side rails determined to be physical restraints will be referred to the physical restraint reduction committee.
5. Residents using side rails/**turning bars** determined to be assistive device(s) will consent to use (per Assistive Device Consent form).
 - a. Consent form will be completed by the interdisciplinary committee and forwarded to Social Services to obtain signed consent from the appropriate party (ies).
 - b. A separate consent form will be used for each type of assistive device.
 - c. Changes to the assistive device (other than to discontinue) will be noted on the existing consent form and consent to the changes documented.

02/02, Revised 03/04, 07/07, 01/09, 09/14, **10/19**; Reviewed 11/13

ASSISTIVE DEVICE – CONSENT FOR USE

It is the facility policy that residents be informed of the potential benefits and risks of assistive devices. There are times in which resident requests or requires assistive devices to improve posture, decrease potential for injury, or maintain physical function. It is our practice to involve the resident and his/ her family in the decision to use these types of assistive devices. All devices are monitored closely, and their use reviewed frequently.

The family has been consulted at the time of order.

Date _____ Staff Member _____

With all assistive devices, there are potential benefits and risks involved. These may include, but are not limited to:

<u>Potential Benefits</u>	<u>Potential Risks</u>
Prevents falls which might result in injury Allows medical treatments to proceed without interference objects Maintains body alignment Protects resident, other residents, or staff from harm Increases feeling of safety and/ or security Reminds resident not to get out of bed without assistance Assists resident to reposition or turn in bed Assists resident to get in/out of bed Helps prevent rolling out of bed Provides convenient access to call lights, etc.	Prevents resident from retrieving objects Injuries resulting in trying to get out of the assistive device Incontinence of bowel/bladder Loss of skin integrity Increases agitation, anxiety or withdrawal from social contact Bed entrapment

I have read and weighed the above benefits and risks and evaluated the need for the following order as described. I agree to the use of the described restraint or device for the listed purpose. I also understand that I will be notified if these devices are changed in the future.

Signature of Resident or Representative _____ Date _____
 Signature of Health Care Professional _____ Date _____

*Specific Order

Changes made:

Date	Changes(s) in existing Order	Family Notified (Y/N)	Staff initial

*Use a separate consent form for each type of assistive device utilized

Resident's Name _____ Physician _____ MR # _____

3/04, Revised 6/07, Reviewed 11/13

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 on the treatment sheet.
 - a. The treatment sheet shall indicate: Skin Assessment q week - (-) indicates absence of skin problems, (+) indicates presence of skin problem(s) - specifics documented ~~on reverse side in Emar~~.
 - b. 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 BVH Braden Scale – for Predicting Pressure Sore Risk in Point Click Care (PCC) Assmnts tab.
 - a. Admission assessment (head-to-toe skin assessment) will be completed by the admitting nurse (or designee) within six (6) hours of admission. If the resident has a current pressure ulcer and /or a history of a prior healed pressure ulcer, then the admitting nurse or skin wound nurse shall document, in detail, the status of the site(s).
 - b. Admission assessment will be completed by the admitting nurse or unit RN Manager or designee (See BVH Braden Scale).
 - c. Quarterly assessments (BVH Braden Scale) will be completed by the unit RN Manager or designee, in conjunction with the MDS schedule.
 - d. Skin assessment forms will be located in the Point Click Care (PCC) Assmnts tab of each resident's medical record.
3. All identified skin integrity issues/problems (see # 1 & 2) will be communicated to the skin wound nurse and/or Unit RN Manager.
4. Skin/Wound nurse ~~and/or Unit RN Manager~~ will evaluate residents upon admission, those 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. (See procedure related to skin/wound nurse responsibilities.)

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 above problems.
3. The Director of Nursing Services and the facility leadership team will ensure procedures are consistent with current standards.

10/00, revised 05/01, 05/02, 01/03, 10/03, 03/04, 03/05, 04/05, 02/06, 06/06, 12/12, 09/14

BRADEN SCALE ASSESSMENT

Purpose

The BVH Braden Scale – For Predicting Pressure Ulcer Risk is used to assess a resident’s potential for skin breakdown and to assist in determining appropriate interventions to prevent or heal impaired skin integrity. The procedure should be used in conjunction with the Skin Assessment Program procedure.

The following procedure is a guide in the completion of the skin assessment form.

1. The BVH Braden Scale shall be completed on each resident upon admission, re-admission, and quarterly, annually and in the event of a change of condition. This BVH Braden Scale will be completed in Point Click Care (PCC) Assmnts tab.
2. The BVH Braden Scale is designed to assess the resident condition/status as it relates to Sensory Perception, Moisture, Activity, Mobility, Nutrition, and Friction or Shear.
 - a. For each of the above areas assessed there is typically only one category that best describes the resident’s current condition.
 - b. In each assessment period the resident will be assessed in each category. Using a scale of 1-4, whichever best describes the resident. The numbers will then be totaled, and the total score will be indicated in the header of the assessment. The scoring will be done by PCC.
 - c. Based on the score, a resident will be either at mild risk (15-18), moderate risk (13-14), high risk (10-12), or severe risk (<9) for developing pressure ulcers.
 - d. The form shall be electronically signed and locked by the licensed nurse conducting the assessment.
3. In addition to the items assessed on the BVH Braden Scale, the resident’s cognitive status, peripheral blood flow, cooperation with cares/interventions, and current/prior skin integrity problems will be assessed. These additional items will not change the BVH Braden Scale Score but will assist staff in determining the most appropriate care plan interventions and the most accurate level of risk.
4. Based on the resident’s assessment in each of the items described above:
 - a. Appropriate care plan interventions shall be implemented to assist in maintaining skin integrity and/or healing skin problems. (See Care Plan Skin-Wound)
 - b. If a resident scores at high or severe risk, the Registered Dietician will evaluate for adequate nutritional intake related to skin integrity.
 - c. If a resident scores at high or severe risk, the Skin/Wound nurse and/or unit RN Manager will be notified and further interventions will be implemented as appropriate.
5. Any resident with a current/prior history of a pressure sore(s) will be determined as severe risk for predicting pressure sores (regardless of BVH Braden Scale Score).

4/05, 11/05, 02/06, 06/06, 12/12, 09/14

SKIN/WOUND NURSE RESPONSIBILITIES

To assist the facility in the prevention, identification, monitoring, and healing of residents' skin issues, the skin/wound nurse responsibilities are as follows:

Skin/Wound Program Responsibilities

1. Serve as facility subject-matter expert related to skin and wound issues and wound dressing and healing.
2. Maintain liaison with VAMC medical and nursing staff related to wound treatment issues, orders, and appointments.
3. Conduct facility in services related to skin/wound issues/dressing changes (~~at least quarterly~~). **biannually**.
4. Complete Skin/Wound QA monitors as appropriate.
5. Maintain records of manufacturer's recommended pressure relieving ratings, pressure relieving device supply sources, inventory of facility pressure relieving devices, and other records as appropriate.
6. Respond to question from staff, families, physician, etc. related to skin/wound issues.

Skin Breakdown Prevention Responsibilities

Monitor/audit each resident's weekly skin assessment to ensure completeness and accuracy – provide feedback to Unit RN Manager as appropriate.

1. Conduct comprehensive skin assessment on all new admits and re-admits. Document results of skin assessment.
2. Implement appropriate pressure relieving devices to prevent skin breakdown.
3. Consult with nursing staff and Unit RN Manager to develop appropriate and specific care plan interventions to prevent skin breakdown.
4. Monitor facility staff to ensure prevention pressure relieving devices are utilized/implemented as care planned.

Wound Identification/Documentation/Dressing/Healing

1. Review skin/wound communication book and follow-up referrals. Consult with staff on each unit related to identified skin issues as appropriate.
2. Refer residents with pressure wounds to Nutrition at Risk (N. A. R.) Committee and participate in N. A. R. Committee meetings.
3. Prepare weekly skin assessment (wound) report and present report to the ~~facility Stand-Up Committee meeting~~ **Leadership Team** each ~~Friday~~. ~~Wednesday~~. Distribute report to appropriate facility staff.
4. Consult with resident's primary physician to determine appropriate wound dressing, vitamin, and other wound healing orders.
5. Monitor resident's environment to ensure pressure relieving devices are utilized as care planned.

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6. Educate staff related to care plan interventions as needed.
7. Complete BVH Weekly Pressure Ulcer Healing Record in Point Click Care (PCC) Assmnts tab for each resident with a pressure wound.
8. Document wound assessment in Progress Notes of medical record in Point Click Care (PCC).
9. Monitor wound healing status and adjust wound care orders (with physician) as appropriate.
10. Assist provider in determining when wound is healed, document in PCC and updated CP approp.
11. Perform clean/sterile dressing changes as ordered.
12. Observe licensed staff changing wound dressing and document performance.
13. Audit TAR/Alert charting records/documentation to ensure compliance with wound assessm
14. Notify unit RN Manager of audit findings.

03/05, revised 02/06, 12/12, 09/14

SMOKING

Purpose

Smoking procedures for this facility are necessary for ensuring the safety of each resident, staff member, and visitor. The Administrator has the ultimate responsibility for enforcing the facility smoking procedure; however, it is the responsibility of each staff member to be aware of the smoking privileges provided to EACH resident and assist in ensuring they are in compliance with the procedure.

Procedure

Resident smoking is allowed only in designated smoking areas around the facility. No other area is available for smoking by anyone.

Residents will be assessed for their safety and ability to handle their own smoking materials. Residents will be allowed smoking materials based on this assessment. Staff, family and friends will be informed regarding the facility's procedure, if the resident is allowed to have smoking items (including matches or lighter) at the bedside or whether these items will be located at the nurses' station, the level of supervision and the use of any safety enablers such as a smoking apron.

Residents who wish to smoke will be assessed using the BVH Smoking Classification Assessment in Point Click Care (PCC) Assmnts tab. Based on the responses and consultation with facility staff, the RN Manager or designee will determine appropriate level of supervision. Residents will be classified into one of the following four categories:

1. WITHOUT SUPERVISION:

- a. These residents will be allowed to keep cigarettes and matches/lighters in a safe area. This area must be in a location so that other residents will not have access to them.
- b. These residents have the ability to:
 1. Ensure their oxygen is turned off and that the portable oxygen device is not taken into the smoking area, either by consistently doing this for themselves or by consistently asking staff to complete the task. The portable oxygen device may be left in the resident's room or placed in the designated portable oxygen device "parking spot".
 2. Don a fire proof smoking apron, if appropriate, either by consistently doing this for themselves or by consistently asking staff to complete the task.
 3. Smoke in the appropriate place.
- c. These residents will be allowed to come and go from the smoking areas unattended.

2. SUPERVISION:

- d. These residents have been assessed and it has been determined that they may be allowed to keep their smoking materials in a safe area, or the smoking materials may be kept at the nurses' station.
- e. They may light their own cigarette or ask staff to light the cigarette for them.
- f. These residents have been assessed and it has been determined that their smoking materials are to be kept at the nurses' station.
- g. They may ask staff to light the cigarette for them or may light the cigarette for themselves before returning the lighter/unused matches to nursing staff.
- h. Staff will ensure that:
 - 1. Resident is assisted to appropriate designated smoking area.
 - 2. Portable oxygen is turned off and the portable oxygen device is not taken into the smoking area. The portable oxygen device may be left in the resident's room or placed in the designated portable oxygen device "parking spot".
 - 3. Resident is wearing a fire proof smoking apron, if appropriate.
 - 4. When these residents are in the smoking area, staff must observe them no less than every fifteen (15) minutes.

4. EXTENSIVE SUPERVISION:

- i. When these residents wish to smoke, they will need to ask staff members for the supplies and staff will accompany them to the smoking area and light the cigarette for them.
- j. While these residents are in the smoking area staff must observe them and/or assist as needed, including turning off oxygen and ensuring that the portable oxygen device is not taken into the smoking area. The oxygen companion may be left in the resident's room or placed in the designated oxygen companion "parking spot".
- k. **Residents will remain in line of sight of staff.**
- l. Residents' care plans will be developed or adjusted to reflect their smoking assessment and classification, along with other related smoking interventions.

Resident's smoking abilities will be re-assessed in the event of a change of condition, change in function of any kind, a start or change in portable oxygen use that would affect their safety with the smoking program or at least quarterly, in conjunction with the focus charting guidelines utilizing the BVH – **Quarterly** Smoking Assessment in Point Click Care (PCC) Assmnts tab.

All residents who are smokers and utilize a portable oxygen device will have a Fire Safe Cannula Valve as a precautionary measure.

Staff and visitors must smoke in the designated areas only.

Revised 2/03, 6/06, 5/07, 01/09, 11/10, 04/12, 09/14

ULCER / ABRASION / SKIN TEAR / BRUISE ASSESSMENT & DOCUMENTATION

Purpose

To ensure complete and comprehensive assessment, monitoring and documentation of residents' skin/wound issues.

Procedure

The following will be used as a guide when assessing, monitoring and documenting a resident's pressure ulcer, stasis ulcer, abrasion, skin tear, and/or bruise. **Ulcers/Wounds** will be assigned to the **AM shift**. **Abrasions and Skin Tears and Bruises** will be assigned to the **PM shift**. If the wound requires a dressing change, then the shift assigned to assess the wound will be responsible for the dressing change.

1. Pressure Ulcer/Stasis Ulcer/Wounds

A resident with an ulcer/wound shall ~~be placed on alert charting~~ ~~have charting that~~ (AM Shift) ~~and this charting~~ will continue with each dressing change until the wound is healed. The following information should be included in the Progress Notes in Point Click Care (PCC) Medical Record of resident:

- a. Location of wound.
- b. Condition of surrounding skin.
- c. Condition of dressing (if dressing is dry and intact and not scheduled to be changed then that is all the assessment/documentation that will be necessary).
- d. Condition of wound bed – granulation, color.
- e. Exudate – describe color and amount.
- f. Odor, if present.
- g. Pain – if pain is present r/t to wound / wound care. Indicate the interventions instituted.
- h. Update MD of wound changes as needed.

2. Abrasions

A resident with an abrasion will have a monitor (PM Shift) initiated (T. O. required) to continue until the abrasion is healed. The order shall be written and entered on the TAR:

"Monitor abrasion located (insert site), cm X cm QPM until healed then DC. Doc "Y" if there are no s/s of infection and pain is managed. Doc "N" if exceptions, select chart code 9 'other/see progress notes' and progress note findings"

If there are s/s of infection in the abrasion, then the following shall be implemented.

- a. Document as indicated on the eTAR the s/sx of infection e.g. redness, swelling, exudate, odor and if there is pain associated with the wound.
- b. Notify the RN Unit Manager and the Skin/Wound nurse of the changes

- c. Notify MD of the changes.

3. Skin Tear

A resident with a skin tear will have a monitor (PM Shift) initiated (T.O. required) to continue until the skin tear is healed. The order shall be written and entered on the TAR:

"Monitor skin tear located (insert site), cm X cm QPM until healed then DC. Doc "Y" if there are no s/s of infection and pain is managed. Doc "N" if exceptions, select chart code 9 'other/see progress notes' and progress note findings"

If there are s/s of infection in the skin tear, then the following shall be implemented:

- a. Document as indicated on the eTAR the s/s of infection e.g. redness, swelling, exudate, odor and if there is pain associated with the wound.
- b. Notify the RN unit Manager and the Skin/Wound nurse of the changes.
- c. Notify MD of the changes

4. Bruise

A resident with a bruise will have a monitor (PM Shift) initiated (T.O. required) to continue **for 3 days. until the bruise(s) is healed.** The order shall be written and entered on the eTAR:

"Monitor bruise located (insert site), cm x cm QPM until healed then DC. Doc "Y" if there is no change or a decrease in size, no s/s of infection and pain is managed. Doc "N" if exceptions, select chart code 9 'other/see progress notes' and progress note findings."

If there are adverse changes and/or s/s of infection with the bruise **or bruise gets bigger**, then the following shall be implemented:

- a. Document as indicated on the eTAR the changes in size and/or s/s of infection e.g. redness, swelling, exudate, odor and if there is pain associated with the bruise.
- b. Notify the RN Unit Manager and the Skin/Wound nurse of the changes.
- c. **If bruise increases in size, continue to monitor until healing begins.**
- d. Notify MD of the changes.

5. Once the ~~pressure ulcer/stasis ulcer~~, abrasion, skin tear, and/or bruise has healed:

- ~~a. Complete form to~~ Remove order and/or monitor from eTAR ~~. or obtain MD order to discontinue.~~
- ~~b. Submit to unit clerk for processing.~~
- c. Discontinue care plan.

02/06, revised 08/06, 05/08, 10/08, 11/08, 2/09, 12/12, 09/14, 11/14, 10/19

WOUND DOCUMENTATION – INITIAL / NEWLY DISCOVERED

The licensed nurse assigned to a resident who has been identified as having a newly discovered wound shall:

1. Identify **possible** cause of the wound, if possible, e.g. shoes, mattress on bed, rubbing on something. Remove or change the cause to prevent reoccurrence if possible.
2. Obtain an order for an appropriate treatment from physician.
3. Initiate a care plan for the wound.
4. Initiate alert charting.
5. Document in the medical record a complete description of the wound:
 - a. Location
 - b. Wound bed: Description of wound edges, surrounding tissue (e.g. surrounding tissue is pink and blanching)
 - c. Any drainage or odor: Description of drainage (i.e. scant, serous, no drainage, etc.)
 - d. Wound measurement: Length x width. Using centimeter ruler: Length is measured by greatest head to toe diameter and width is the greatest width left to right.
 - e. If pain is present on palpation
 - f. **Potential** Causes of the wound and if the cause has been removed or altered
 - g. What intervention and/or treatment you have put into place to aid in the healing of the wound.
6. Notify the wound nurse by making a note in the skin/wound communication book located at the nursing station.
7. Notify the RN Manager; leave a voice mail, call at home, note under the office door, etc.
8. Notify the MD.

08/06, revised 12/12, 09/14, 04/16, 10/19

VISION SERVICES / ASSESSMENT

1. All residents will be evaluated for the need for vision (optical) services upon admission and at least annually thereafter.
2. 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.
3. The resident's physician (or designated nursing professional) shall conduct a vision assessment using the following standardized method (in conjunction with the MDS coding requirements). For this assessment the resident should wear glass, if applicable.
 - a. Sitting/standing in front of resident, show resident "newspaper print" sheet and ask resident to read and recite. If resident is unable to do so, proceed to step B.
 - b. Sitting/standing in front of resident, show resident "newspaper headline print" sheet and ask resident to read and recite. If resident is unable to do so proceed to step C.
 - c. Sitting/standing in front of resident, lower multi-colored blocks (e.g. Legos) from above eye level to below eye level and place them in front of resident. Assess if the resident's eyes track the movement of the blocks and/or resident reaches out to grab/touch the blocks.
 - d. Document response to any or all of the above tests in the medical record (e.g. focused charting).
4. Eye glasses shall be labeled by the unit Senior Certified Nursing Assistant or designee.
5. The resident's care plan shall be updated by the RN Unit Manager or designee as applicable.

12/03, Reviewed 11/13

NOTIFICATION OF CHANGES

Purpose

To ensure that the resident, the resident's legal representative or interested family member (if known) and the resident's physician are notified of resident changes.

Procedure

1. The resident, the resident's legal representative or interested family member (if known) and resident's physician are immediately notified in the event of resident changes which include but are not limited to:
 - a. Accident or incident involving the resident;
 - b. Significant change in the resident's physical, mental, or psychosocial status;
 - c. Need to alter treatment (i.e., a need to discontinue an existing form of treatment/medication, or to commence a new form of treatment/medication); or
 - d. Decision to transfer or discharge the resident from the facility.

The licensed staff caring for this resident at the time that the resident change occurs is responsible for notifying resident, the resident's legal representative or interested family member of the above changes. Licensed staff includes: RN Manger, RN, LPN, Social Worker, PT, OT, and ST.

2. The facility will also promptly notify the resident, the resident's legal representative or interested family member (if known) when there is:
 - a. Change in room or roommate assignment; or
 - b. Change in resident rights under Federal or State law or regulation

Notification of this type is designated to the Social Worker assigned to the care of the individual resident, however licensed nursing staff (RNM, RN or LPN) may complete the notification as needed.

3. An ISVH-B resident may choose to exercise their right to privacy and ask that the facility not notify family members in the event of a significant change. The facility licensed staff will document and honor this request.

12/11, Reviewed 11/13

RESIDENT ASSESSMENT – COORDINATION WITH PASARR PROGRAM

Procedure

This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.

Procedure Explanation and Compliance Guidelines

1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State’s Medicaid rules for screening.
 - a. PASARR Level I – initial pre-screening that is completed prior to admission
 - i. Negative Level I Screen – permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.
 - ii. Positive Level I Screen – necessitates a PASARR Level II evaluation prior to admission.
 - b. PASARR Level II – a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.
2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.
3. A record of the pre-screening shall be maintained in the resident’s medical record.
4. Exceptions to the preadmission screening program include those individuals who:
 - a. Are readmitted directly from a hospital.
 - b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services.
5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days:
 - a. The facility must screen the individual using the State’s Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.
 - b. The Level II resident review must be completed within 40 calendar days of admission.

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6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.
7. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.
8. Any level II resident and all other residents who experiences a significant change in status assessment will have their PASARR reviewed for accuracy and if indicated will be referred to the state mental health or intellectual disability authority for additional resident review.
9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include:
 - a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).
 - b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.
 - c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

Revised 12/18

ASSISTIVE DEVICE – CONSENT FOR USE – FORM

It is the facility policy that residents be informed of the potential benefits and risks of assistive devices. There are times in which resident requests or requires assistive devices to improve posture, decrease potential for injury, or maintain physical function. It is our practice to involve the resident and his/ her family in the decision to use these types of assistive devices. All devices are monitored closely, and their use reviewed frequently.

The family has been consulted at the time of order.

Date _____ Staff Member _____

With all assistive devices, there are potential benefits and risks involved. These may include, but are not limited to:

<p><u>Potential Benefits</u> Prevents falls which might result in injury Allows medical treatments to proceed without interference objects Maintains body alignment Protects resident, other residents, or staff from harm Increases feeling of safety and/ or security Reminds resident not to get out of bed without assistance Assists resident to reposition or turn in bed Assists resident to get in/out of bed Helps prevent rolling out of bed Provides convenient access to call lights, etc.</p>	<p><u>Potential Risks</u> Prevents resident from retrieving objects Injuries resulting in trying to get out of the assistive device Incontinence of bowel/bladder Loss of skin integrity Increases agitation, anxiety or withdrawal from social contact Bed entrapment</p>
---	---

I have read and weighed the above benefits and risks and evaluated the need for the following order as described. I agree to the use of the described restraint or device for the listed purpose. I also understand that I will be notified if these devices are changed in the future.

Signature of Resident or Representative _____ Date _____

Signature of Health Care Professional _____ Date _____

*Specific Order

Changes made:

Date	Changes(s) in existing Order	Family Notified (Y/N)	Staff initial

*Use a separate consent form for each type of assistive device utilized

Resident's Name _____ Physician _____ MR # _____

BLADDER DATA COLLECTION 3-DAY VOID PATTERN

Resident's Name _____ Date _____

Day 1					Day 2					Day 3				
Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comments	Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comments	Time of Day	Voided in Toilet (x)	Aware of Urge to Void?	Was Incontinent (Circle one)	Comments
7:00 am		Yes/no	S/M/L		7:00 am		Yes/no	S/M/L		7:00 am		Yes/no	S/M/L	
8:00 am		Yes/no	S/M/L		8:00 am		Yes/no	S/M/L		8:00 am		Yes/no	S/M/L	
9:00 am		Yes/no	S/M/L		9:00 am		Yes/no	S/M/L		9:00 am		Yes/no	S/M/L	
10:00 am		Yes/no	S/M/L		10:00 am		Yes/no	S/M/L		10:00 am		Yes/no	S/M/L	
11:00 am		Yes/no	S/M/L		11:00 am		Yes/no	S/M/L		11:00 am		Yes/no	S/M/L	
Noon		Yes/no	S/M/L		Noon		Yes/no	S/M/L		Noon		Yes/no	S/M/L	
1:00 pm		Yes/no	S/M/L		1:00 pm		Yes/no	S/M/L		1:00 pm		Yes/no	S/M/L	
2:00 pm		Yes/no	S/M/L		2:00 pm		Yes/no	S/M/L		2:00 pm		Yes/no	S/M/L	
3:00 pm		Yes/no	S/M/L		3:00 pm		Yes/no	S/M/L		3:00 pm		Yes/no	S/M/L	
4:00 pm		Yes/no	S/M/L		4:00 pm		Yes/no	S/M/L		4:00 pm		Yes/no	S/M/L	
5:00 pm		Yes/no	S/M/L		5:00 pm		Yes/no	S/M/L		5:00 pm		Yes/no	S/M/L	
6:00 pm		Yes/no	S/M/L		6:00 pm		Yes/no	S/M/L		6:00 pm		Yes/no	S/M/L	
7:00 pm		Yes/no	S/M/L		7:00 pm		Yes/no	S/M/L		7:00 pm		Yes/no	S/M/L	
8:00 pm		Yes/no	S/M/L		8:00 pm		Yes/no	S/M/L		8:00 pm		Yes/no	S/M/L	
9:00 pm		Yes/no	S/M/L		9:00 pm		Yes/no	S/M/L		9:00 pm		Yes/no	S/M/L	
10:00 pm		Yes/no	S/M/L		10:00 pm		Yes/no	S/M/L		10:00 pm		Yes/no	S/M/L	
11:00 pm		Yes/no	S/M/L		11:00 pm		Yes/no	S/M/L		11:00 pm		Yes/no	S/M/L	
Midnight		Yes/no	S/M/L		Midnight		Yes/no	S/M/L		Midnight		Yes/no	S/M/L	

1:00 am		Yes/no	S/M/L		1:00 am		Yes/no	S/M/L		1:00 am		Yes/no	S/M/L	
2:00 am		Yes/no	S/M/L		2:00 am		Yes/no	S/M/L		2:00 am		Yes/no	S/M/L	
3:00 am		Yes/no	S/M/L		3:00 am		Yes/no	S/M/L		3:00 am		Yes/no	S/M/L	
4:00 am		Yes/no	S/M/L		4:00 am		Yes/no	S/M/L		4:00 am		Yes/no	S/M/L	
5:00 am		Yes/no	S/M/L		5:00 am		Yes/no	S/M/L		5:00 am		Yes/no	S/M/L	
6:00 am		Yes/no	S/M/L		6:00 am		Yes/no	S/M/L		6:00 am		Yes/no	S/M/L	

Product Worn (circle item): **Pad, Panty liner, Brief Other** (specify) _____ (*) **S** = Slightly Wet **M** = Wets Most of Pad **L** = Outside of Clothing is Wet

Reviewed by: _____ Physician Review: _____

Neurological Checklist (FRONT)

This checklist should be completed at the following intervals for follow up for all unwitnessed falls or falls in which head is struck. Any change in resident condition requires a phone call to the primary care physician.

- Initial assessment followed by q15 min x 4, q30 min x 2
- Every hour x 2
- Once per shift for 72 hours (9 shifts, D=day, E=evening, N=night)

Resident name: _____ Room #: _____

Description	B*	Medical record #:																	
		q15 x 4	q30 x 2	q1 x 2	Every shift X 72 hours	(9 shifts D, E, N)													
Date																			
Time or shift																			
Vital Signs																			
Assess blood pressure for increase or decrease. Assess pulse for slowing or widening pulse, then increase rate. Assess respirations for change in rate, rhythm, pattern, and rate of expiration.																			
Blood Pressure																			
Pulse																			
Respirations																			
Orientation (write "check mark (✓)" for yes and "0" for no)																			
Place																			
Person																			
Date/Time																			
Eye Responses: A. Eyelid Movement																			
4 = Opens eyes spontaneously and purposely 3 = Opens eyes only in response to speech ("Please open your eyes.") 2 = Opens eyes in response to pain (apply blunt pressure with an object such as a pencil to the fingernail where it enters the skin of the finger) 1 = Does not open eyes when painfully stimulated U = Unstable																			
Eye Score																			

(see back to complete form)

Falls: Neurological Checklist (back)

Description	B*	Medical record #:																	
		q15 x 4	q30 x 2	q1 x 2	Every shift X 72 hours	(9 shifts D, E, N)													
Eye Response: B. Pupil																			
(+) = Reactive (-) = Non-reactive (c) = cannot cooperate										In Millimeters									
Right size																			
Right reaction																			
Left size																			
Left reaction																			
Hands, Right/Left: Check if right and left responses are the same.																			
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																			
Right hand																			
Left hand																			
Arms, Right/Left: Check if right and left responses are the same. It is necessary to know the resident's baseline ability for arm and leg strength.																			
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																			
Right arm																			
Left arm																			
Legs, Right/Left: Check if right and left responses are the same. It is necessary to know the resident's baseline ability for arm and leg strength.																			
4 = Normal power 3 = Mild weakness 2 = Severe weakness 1 = No response																			
Right leg																			
Left leg																			
Notifications: Yes or N/A (document time, name, outcome in Nurse's Notes)																			
Physician notified if change in status																			
Family notified if change in status																			
Nurse's Initials																			

*B = Baseline (this is 1st set of vitals and neuro following fall)

Document available at www.primaris.org

MO-08-63-0017 July 2008 This material was prepared by Primaris, the Medicare Quality Improvement Organization for Missouri, under contract with the Centers for Medicare & Medicaid Service (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.



PRECAUTION – OBSERVATION FORM

(Initial Q 15 minutes – 24 hrs. QD)

PLEASE INDICATE LOCATION OF RESIDENT FROM THE KEY (bottom of page) AT SPECIFIED TIME. PLACE NUMBER IN LOCATION BOX AND INITIAL.

TIME	LOCATION	INITIALS	TIME	LOCATION	INITIALS	TIME	LOCATION	INITIALS
0600			1400			2200		
0615			1415			2215		
0630			1430			2230		
0645			1445			2245		
0700			1500			2300		
0715			1515			2315		
0730			1530			2330		
0745			1545			2345		
0800			1600			2400		
0815			1615			0015		
0830			1630			0030		
0845			1645			0045		
0900			1700			0100		
0915			1715			0115		
0930			1730			0130		
0945			1745			0145		
1000			1800			0200		
1015			1815			0215		
1030			1830			0230		
1045			1845			0245		
1100			1900			0300		
1115			1915			0315		
1130			1930			0330		
1145			1945			0345		
1200			2000			0400		
1215			2015			0415		
1230			2030			0430		
1245			2045			0445		
1300			2100			0500		
1315			2115			0515		
1330			2130			0530		
1345			2145			0545		

LOCATION KEY: 1=Bed 2=Dining Room 3=Activities 4=Bathroom 5=Hall 6 = Common Area (TV Room)

RESIDENT: _____ DATE: _____

ROOM: _____

SEIZURE EVALUATION WORKSHEET

Resident's Name _____

Room _____ Date _____ Time _____ Duration of Seizure (approx.) _____

INITIATE NEURO WORKSHEET

SEIZURE (HARD – MAJOR) – Check all that apply:

- _____ Eyes Turn_Right Side_Left Side
- _____ Twitching of face Right Side_Left Side
- _____ Difficulty breathing_Before_During_After
- _____ Color changes of skin, lips and/or nail beds
- _____ Sudden loss of consciousness
- _____ Falls to ground or floor
- _____ Body rigid with general trembling of extremities
- _____ Extremities thrash violently:_R Arm_L Arm_R Leg_L Leg
- _____ Tongue biting
- _____ Loss of bladder control
- _____ Frothing at the mouth
- _____ After seizure, falls into deep sleep
- _____ After seizure, confused or disoriented

SEIZURE (LIGHT – MINOR) – Check all that apply:

- _____ Head falls forward abruptly
- _____ Drops to floor and up quickly
- _____ Unconsciousness only momentarily
- _____ Blinking or fluttering of eyelids
- _____ Blank Stare
- _____ Slight turning of eyes
- _____ Momentarily stiffening of extremities

Additional Comments:

The above information is designed to assist staff in evaluating a resident's seizure activity – information should be used to help formulate documentation into nurse progress notes and assist in communicating seizure information to physician.

THIS WORKSHEET SHOULD NOT BE PLACED IN THE RESIDENT'S MEDICAL RECORD.

05/02, Revised 02/03

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BATHING PROCEDURE

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 needs and preference and updated by the RN Unit Manager.
2. On day one of an admission or transfer to a unit 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 POC.
2. If a resident refuses a bath/shower then the CNA will document the ADL's bathing task in POC as Resident Refused. Additional information about the refusal may also be documented in POC under the 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 of the refusal. Re-approach the resident after a short time period and re-offer the bath/shower. If possible, have another staff member attempt to engage the resident in participation. If refusal continues, refer also to Resident Cares Guidelines procedure.
4. Nurse assigned resident is responsible for ensuring the resident receives bath/shower per schedule and/or the resident's preference.

Bath Aide/CNA:

1. The Bath Aide/CNA 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 residents and other designated residents.)
2. Bed linens are to be changed a minimum of once weekly.

01/00; Revised: 04/00, 06/00, 02/03, 10/03, 10/10, 05/14, 10/15, 12/18

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
Perform hand hygiene	
Lower backrest to flat position.	Raise bed to work level.
Move bedside table and chair.	Will allow ample work area.
Place pillow and linen on chair.	Arrange in order of use.
Remove linen from bed one article at a time.	Fold reusable linen and place on chair; discard other linen into laundry bag.
Push mattress to head of bed.	
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.	If only one clean sheet is being used, it is preferable to use it as top sheet.
Place second sheet lengthwise on head end of bed even with mattress edge.	
Tuck in sheet at bottom and make square corner.	
Place spread lengthwise on bed.	Arrange top edge about ten inches from head of bed.
Tuck in spread at bottom and make mitered corner.	
Go to other side of bed.	Fold back bedding to bottom sheet.
Repeat steps 9 through 13.	Tighten linen as much as possible, but allow for foot room.
Turn edge of top sheet over spread.	
Fan-fold top bedding to lower end of bed.	
Slip pillow into pillow case.	
Place pillows on bed.	Push corners of pillow into corners of pillow case.
Replace bedside table and chair	Place seamed side away from patient.
Lock wheels of bed.	
Attach bell cord to sheet with clip.	To prevent accidents. Pins are not used, as they may damage linen and mattress cover.
Leave bed in low position at all times.	

08/17

RESIDENT CARES GUIDELINES

Procedure

1. The AM, PM, and NOC cares provided to residents in this facility will be documented in Point of Care (POC).
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. The information as to the specific care refused or resisted is to be documented in POC in the Behavioral Symptoms 3.0 → Resists/Rejects Evaluation of Care. Also create a custom alert with appropriate documentation as needed.
3. Re-approach the resident after a short time period to attempt to provide the care. If possible, have another staff attempt to engage the resident in participation. Up to three (3) attempts should be made.
4. 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 such as educate the resident on the risks presented by the refusals and document actions/findings/education in the nurse progress note section of the medical record, i.e. Point Click Care.
5. Social Services reviews the Behavioral Symptoms and custom behavior alerts in POC and monitors for refusal of cares and forward the concern to the Inter-Disciplinary Team (IDT) for review and development of interventions to address the refusals.
6. Resident family/legal representative will be informed of the refusals.
7. Resident's physician will be notified if the refusals result in potential resident harm. This notification may be warranted immediately upon refusal if harm is imminent.
8. Resident's plan of care will be updated to include the refusals.

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 Shaving resident as needed
- Toileting/peri-care as appropriate
- Removing soiled linen/clothing from room Passing Water/Ice
- Tidying room
- Ensuring appropriate fall prevention/skin integrity protection devices are in place Ensure alarms are in place and turned on
- 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

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- 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 Test and put hearing aid(s) in ear(s).
- Wash and put on glasses.

PM Cares:

- Dressing/assisting resident into appropriate bed clothing Removing/washing dentures
- Providing oral hygiene Washing face & hands Combing/brushing hair
- Toileting/peri-care as appropriate Removing soiled linen/clothing from room Passing Water/Ice
- Tidying room
- Ensuring appropriate fall prevention/skin integrity protection devices are in place Ensure alarms are in place and turned on
- 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
- 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 Removing/washing 'ted' hose
- Moving/washing shoes/footwear
- Take hearing aid(s) out and put in safe place Take glasses off and put in safe place

NOC Cares

- Changing resident clothing as appropriate Washing face & hands (if applicable) Toileting/peri-care as appropriate Removing soiled linen/clothing from room Passing Water/Ice
- Tidying room
- Ensuring appropriate fall prevention/skin integrity protection devices are in place. Ensuring alarms are in place and turned on
- Placing call light within reach of resident Repositioning resident as needed Offering fluids
- Checking residents' skin, report red or open areas to licensed staff Reporting BM status to licensed staff
- Cleaning wheelchairs weekly + PRN per wheelchair cleaning schedule Change equipment/supplies per Nursing Procedure Manual – Section VIII Obtaining vital signs as directed by licensed staff

08/00; Revised: 01/00, 01/07, 05/14, 10/15

PROCEDURE FOR BATHING USING THE CENTURY TUB SYSTEM

1. Only fill tub after it has been drained and sanitized. Run water into tub between 100-103°F (water in tub between 94-97°F). Monitor the tub area while filling to ensure that the temperature of the water is in the appropriate range. The Century tub has a display that will show you the temperature of the water flowing into the tub and also the temperature of the water inside the tub. The water level must be above the hydro massage outlet, if you choose to use the hydro massage feature. Tub should be filled before submerging resident.
 - a. The Century bath is equipped with an electronic scalding protection. This scalding protection will activate when the water temperature gets too high (113°F). If the dangerous temperature is reached the water will shut off and the auto fill feature will be interrupted for approx. 10 seconds. After the tub filling LED has stopped flashing, then cold water will need to be added to tub until the temperature of the water inside the tub is between 86-95°F
2. The Century tub utilizes the Alenti lift and hygiene chair to transport and lift the resident into the tub.
 - a. Prior to utilizing the Alenti for a facility resident you need to first assess each resident according to the following criteria: (If a resident does not meet these criteria an alternative bathing method will be used).
 - The resident's weight should not exceed the Safe Working Load of 400lbs.
 - The resident should be active or semi-active (i.e. able to sit upright self-supporting on the side of a bed or toilet).
 - The resident should understand and respond to instructions to stay seated in an upright position.
 - b. Before the resident is transferred to an Alenti ensure that:
 - the Alenti has been disinfected after each use
 - the back rest is attached to the correct side of the Alenti
 - the safety belt is mounted on Alenti
 - the resident is in a correct sitting position on the Alenti
3. Bathing resident in the Century tub.
 - a. Position the Alenti chair next to the end of the tub.
 - b. Raise the Alenti chair to a position where it is clear from the edge of the bath and move the resident over the edge of the tub.
 - c. Position the Alenti chair in the middle of the bath and lower the lift as far as possible.
 - d. If desired and if the resident is capable, rotate the back rest out of the way to allow the resident to recline against the back of the tub.
4. Bathe the resident:

Wash the face area first with the wash cloth. Make sure hands/forearms are submerged. Make sure legs are separated. Turn on hydro massage per resident preference. The tub is equipped with ARJO Shampoo/Body wash and Bath and Body Oil. These are dispensed by pressing corresponding push button on the control panel. Bath time should be 8-10 minutes unless

resident is fearful or unable to tolerate that length of time. At no time should resident be left unattended in the bath.

5. After bathing:

- a. Let the water run out of the bath and sit the resident up. Position the back rest against the residents back, if it had been rotated out of the way. Raise the Alenti chair to a convenient working height and then shower the resident.
- b. Dry the resident and the underside of the seat to prevent water dripping onto the floor. Raise the Alenti chair and pull it away from the end of the bath. Assist the resident to move their legs over the edge of the bath. Do nail care on hands and feet at this time. Assist resident to dress and return to room.
- c. Disinfect the tub and Alenti chair after every resident. Refer to Procedure for disinfecting Century Tub System.

ALTERNATE BATHING PROCEDURE

If a resident prefers a shower or should not have a tub bath, he/she will be assisted by staff. If he/she is ambulatory, the shower will be done using the shower chair. If resident is unable to sit in a shower chair, then the resident will be showered using the shower gurney.

Shower chairs and shower gurney should be disinfected after every use. Refer to Procedure for disinfecting shower chair or shower gurney

If a resident requires a bed bath, you may use a disposable bathing product or use a Septisoft warm towel bath procedure

At no time is any resident to be left unattended in the bath/shower room.

02/03, Revised: 12/04, 10/09, 05/14, 01/15

PROCEDURE FOR DISINFECTING CENTURY TUB SYSTEM

Procedure to be performed before the first bath of the day and then after every resident.

1. Gather supplies:
 - a. protective gloves
 - b. protective glasses
 - c. Disinfectant fluid (Century tub is equipped with an integrated disinfection system, with a spray handle for disinfecting purposes).
 - d. Towel
 - e. Soft Nylon Brush
2. Rinse the tub and scrub tub and accessories to remove visible residue or fluids before disinfecting.
3. Remove the hydro massage plug and Inlet screen.
4. Position the Alenti chair over the bath and lower it down.
5. Close the drainage plug then press the disinfectant button and spray the whole bath tub, hydro massage plug, and Alenti chair with the disinfectant spray handle.
6. Scrub the chair. Make sure to disinfect the underside of the seat as well.
7. Flush the Inlet and hydro massage outlet with disinfectant solution.
8. Allow the disinfectant to take effect according to the recommended time labeled on the bottle.
9. Open the drainage plug then press the button for resident shower on the control panel and rinse the bath tub and accessories carefully until no remaining disinfectant residue is visible.
10. Dry each part of the Alenti chair with a clean cloth.

PROCEDURE FOR DISINFECTING SHOWER CHAIR OR SHOWER GURNEY

1. Gather supplies:
 - a. Protective gloves
 - b. Protective glasses
 - c. Disinfectant fluid (century tub is equipped with an integrated disinfection system, with a spray handle for disinfecting purposed and you may use this on the chair/gurney).
 - d. Towel
 - e. Soft Nylon Brush
2. Detach any cushions or other accessories from the chair.
3. Rinse the chair or gurney and scrub to remove visible residue or fluids before disinfecting. Do the same with the cushions from the shower chair.
4. Using the disinfectant spray down the chair or gurney and all accessories. Using a brush or towel wash all parts of the chair or gurney. Do not forget to clean the underside.
5. Allow the disinfectant to take effect according to the recommended time labeled on the bottle.

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6. Rinse thoroughly with water.
7. Dry each part of the chair or gurney.
8. Once everything is dry attach all accessories or cushions.

Revised: 10/09, 05/14, 01/15

OSTOMY CARE
(Colostomy/Ileostomy)

Purpose

Ostomy care is provided to promote cleanliness and to protect peristomal 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. Perform hand hygiene 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.

11/03, 08/17

FOLEY / UROSTOMY CATHETER CARE

Purpose: To promote hygiene, comfort and decrease risk of infection for catheterized residents.

Each resident with an indwelling catheter will receive catheter care daily and PRN for soiling. (To avoid tension of the catheter and in and out movement of the catheter, it should be secured with a catheter strap.)

Procedure:

1. Supplies for procedure should be readily available
 - a. Soap
 - b. Water
 - c. Gloves
 - d. Clean washcloths
 - e. Alcohol wipes (for use when changing urinary drain bags).
2. Identify the resident.
3. Assemble equipment on a clean surface.
4. Explain the procedure to the resident.
5. Provide privacy.
6. Position resident comfortably. Do not expose unnecessarily.
7. Perform hand hygiene. Put on gloves.
8. Put soap and water on one washcloth; water on the other.
9. For Foley catheter care, use a soapy washcloth, clean the Foley catheter insertion in a downward motion (front to back). Clean the length of the Foley catheter (from patient toward bag).
10. For urostomy care, use a soapy washcloth, clean in a circular motion from site outward. Clean the length of the urostomy catheter.
11. Repeat the procedure using the water-soaked washcloth to rinse.
12. Dry the resident with the clean cloth.
13. Remove gloves and perform hand hygiene.
14. Make the resident comfortable.

CHANGING FROM LEG BAG TO BEDSIDE DRAIN BAG (and VISA VERSA)

1. Supplies for procedure should be readily available:
 - a. Urinary bag
 - b. Alcohol wipes
 - c. Gloves
 - d. Clear plastic bag
 - e. Protective cap
 - f. Specimen container with following information on it:
 - i. Resident's name
 - ii. "CATH CAP HOLDER ONLY" written on cap with Sharpie pen.

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2. Identify the resident.
3. Perform hand hygiene and put on gloves.
4. Clean inside protective cap out of marked storage container in resident's room.
5. Clean inside of protective cap with new sterile alcohol wipe and place aside (resting cap on wipe).
6. Drain urine properly and entirely from the bag that is connected to resident.
7. Disconnect Foley catheter from the bag.
8. Wipe off the end of the drain bag with a new sterile alcohol wipe.
9. Place protective cap on bag being stored.
10. Wipe off the end of the Foley catheter with a new sterile alcohol wipe.
11. Wipe off the end of the bag you are connecting to the Foley catheter with a new sterile alcohol wipe.
12. Connect drain bag (leg or bedside) to Foley catheter tubing.
13. Place drain bag to be stored in a clear plastic bag (labeled with resident's name).
14. Repeat procedure with each change-over.
15. Obtain new bags at least once a week or as indicated.

01/04, revised 02/06, 08/17

FOLEY CATHETER MAINTENANCE

A Foley catheter is a potential source of infection, often causing colonization of bacteria in long-term settings.

1. Catheter irrigations must be ordered and performed by a licensed nurse.
2. Catheters should not be clamped, except for bladder training.
3. Care givers must wear gloves when emptying, measuring, collecting samples of urine, and/or providing care. Empty bag into receptacle, being careful not to contaminate spigot. Wipe after. Observe strict hand-washing between residents.
4. Be aware of signs of urinary tract infections. Symptoms include burning at catheter site, fever, chills, and cloudy or foul-smelling urine. Report any signs to licensed nurse.
5. When resident is up, make sure Foley tubing is not kinked and bag is not dragging on floor area.
6. When resident is in bed, make sure catheter is secured to thigh, so trauma to the urethra will not occur.
7. Urinary bags should be covered when resident is in general population.

01/04, revised 3/06

FOOT CARE / PODIATRY

Purpose:

To provide comfort, prevent skin breakdown, and promote healing of the feet. Procedure

1. Perform foot care as needed and with regularly scheduled bath/shower.
 - a. Lather feet with soap or other prescribed product.
 - b. Gently scrub in and around toenails and between toes.
 - c. Dry feet thoroughly, especially between toes.
 - d. Observe feet for cracks or redness.
 - e. Moisturize feet with a softening lotion.
 - f. Report any adverse skin changes to licensed nurse/physician.
 - g. Do not remove splinters or open a blister, abscess or other infectious process.
2. Protective footwear
 - a. Shoes should have a heavy sole, such as rubber or crepe, a firm center, slightly elevated heel, arch support, and sturdy uppers.
 - b. Shoes and socks always should be dry and clean.
 - c. Socks are used while residents are out of bed. They should be of correct size, preferably free of seams, non-skid bottoms (as appropriate), and changed daily and PRN.
 - d. Do not use constricting socks/shoes and ensure that circulation is not impaired.
3. Residents at risk for skin breakdown on heels/feet.
 - a. Identify residents who are particularly prone to the development of pressure ulcers (use Skin at Risk Assessment) and/or other information to determine susceptibility.
 - b. Develop an individualized care plan to prevent/heal skin breakdown.
 - c. Use heel protectors or other specialized pressure relieving devices as ordered.
4. Podiatry Clinic
 - a. Podiatry Clinic shall be held once a month and coordinated between all nursing units.
 - b. Residents with foot problems will be referred to the clinic at the request of the licensed nursing staff and will be seen at the podiatry clinic by a licensed podiatrist.

01/03, Reviewed 05/14

FRESH WATER PASS

Purpose:

To ensure each resident will have fresh water at his bedside each shift.

Procedure:

1. Aides will be assigned to pass fresh water to each resident each shift. (If resident has swallowing problems, appropriate fluid consistency will be acquired.)
2. Aides will then pass water utilizing the following procedures:
 - a. Obtain ice chest.
 - b. Obtain fresh ice and a clean scoop from the kitchen.
 - c. Place the clean scoop into a scoop holder. (Do not leave scoop in ice/do not place scoop on a towel).
 - d. Empty the existing water from the resident's pitcher into the sink
 - e. Remove scoop from the scoop holder and fill the water pitcher with ice.
 - f. Fill the pitcher with water at the resident's sink, place pitcher where it is readily available to the resident.
 - g. At the end of the shift, drain excess water and ice from the chest and allow to air dry for use by the oncoming shift.
3. On a daily basis, the water pitchers and ice chest will be taken to the kitchen to be run through the dishwasher.

10/02; Revised 02/03, 10/03, 01/07, 12/16

HOT BEVERAGES

Purpose

The purpose of this procedure is to ensure that the residents of the facility receive appropriate assistance with and accessibility to hot beverages.

Procedure

1. Signs will be posted near the hot beverage makers in the large facility dining room designating facility staff the responsibility for obtaining and distributing these beverages.
2. Residents who are cognitively able to request assistance with or can independently obtain the hot beverages available in large dining room will be allowed to do so. They may also ask for assistance from staff, visitors, volunteers, or other residents, as available.
3. No hot beverages will be served from the tray line.
4. No hot beverages carafes will be placed on the feeding assistance tables in the large dining room.
5. Hot beverages will not be served in an activity unless specifically requested by a resident(s) and monitored with close supervision. e.g., hot chocolate at a hockey game, etc.
6. Lids will be placed on all hot beverages obtained outside of the large dining room area, e.g., canteen, nursing units. (To allow for safety in transport, etc.)
7. Hot beverage temperatures shall not exceed 180 degrees.

11/05

PROSTHETICS

1. Prosthetics will be ordered by the individual resident's primary physician.
2. Prosthetics will be care planned in relation to the problem requiring the use of the device and the parameters for use.
3. When applying or removing a prosthetic, nursing staff will monitor stump side for any redness, swelling, bruising, or other skin integrity problems and will 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.

1/03

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ROUNDS / ROUNDS CHECKLIST

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 was provided in accordance with the residents’ care plans and standards of care.

As requested by the unit 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 unit RN Manager for review.

Done	Task	Comments
	Call lights are within reach of resident	
	Resident is appropriately dressed for time of day, season, etc.	
	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, beds are at proper height, etc.	
	Devices (e.g. heel protectors, foot cradles, splints) are on resident and appropriately applied.	
	Environmental/ maintenance (i.e.: wheelchairs, beds, light bulbs, electrical cords, room temperature all working/appropriate)	
	Oral care done am, pm and as needed	
	Other: Ensure each resident is present and/or accounted for.	

Licensed Staff Member Signature: _____

Certified Nursing Aide Signature: _____

Date Submit to unit RN Manager: _____

6/00, revised 02/03, 10/13

FEEDING A RESIDENT

Purpose:

It is a nursing staff's responsibility 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 cloth napkin in place. Ask resident if they would like a clothing protector prior to placing on resident.
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 in Point of Care (POC) under Nutrition – Amount Eaten.
10. 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.

10/03, Revised 05/14

SKIN CARE

In order to promote effective, timely application of skin lotion, creams, gels 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 by CNA as indicated.
2. The licensed nurse will administer skin products that are being used to treat an acute skin condition.
3. The licensed nurse who signs on the eMAR/eTAR for the resident's treatment or procedures is responsible for assuring that all supplies involved are appropriately charged out for that resident in Charge Tracker; such as normal saline, extra protective cream, antiseptic, syringes, q-tip swabs, steri-strips, BG tests, etc.
4. The aide is responsible for reporting any changes in resident skin condition to the licensed nurse for further evaluation.

03/05, revised 07/08, 01/14, 11/14, 05/16

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 Unit Manager and Staff Development Coordinator for evaluation and further intervention.
4. Suction machines are located on each of the nursing units 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 discarded per Equipment/Supplies Cleaning/Disposal Schedule.
8. Canisters assigned residents will be discarded when 2/3rds full and/or when suctioning is no longer necessary.
9. Isolyzer will be used to solidify contents of canister prior to disposal. (See also per Equipment/Supplies Cleaning/Disposal Schedule)

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

1/04, 08/18, 05/19

ROUNDS / ROUNDS CHECKLIST

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 was provided in accordance with the residents’ care plans and standards of care.

As requested by the unit 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 unit RN Manager for review.

Done	Task	Comments
	Call lights are within reach of resident	
	Resident is appropriately dressed for time of day, season, etc.	
	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, beds are at proper height, etc.	
	Devices (e.g. heel protectors, foot cradles, splints) are on resident and appropriately applied.	
	Environmental/ maintenance (i.e.: wheelchairs, beds, light bulbs, electrical cords, room temperature all working/appropriate)	
	Oral care done am, pm and as needed	
	Other: Ensure each resident is present and/or accounted for.	

Licensed Staff Member Signature: _____

Certified Nursing Aide Signature: _____

Date Submit to unit RN Manager: _____

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COMFORT CARE, TERMINAL

Purpose

Terminal comfort care provides supportive care for residents and their families during the end stage of life by enabling them to participate in interactions of their choice, in a supportive environment, with assistance of compassionate caregivers.

Terminal comfort care will be provided in accordance with the following procedure and in conjunction with a physician's order.

Procedure

1. Terminal comfort care is goal directed through planning, implementation and evaluation by the interdisciplinary team of caregivers.
2. Nursing will coordinate the plan of care and will collaborate closely with other disciplines as necessary.
3. Resident shall be re-assessed, as applicable, for changes/potential changes in fall risk, skin breakdown, pain, etc., and plan of care updated as appropriate.
4. Emphasis will be placed on the management of physical and psychosocial needs of the resident.
5. Temporary care plan will be initiated to define appropriate goals and interventions.
6. All treatments and interventions are representative of current standards of care.
7. The goal of terminal comfort care is to keep the resident as comfortable as possible using interventions such as oxygen, turning and repositioning, frequent oral care, offering fluids, etc.

05/02, revised 02/05, 07/09

HOSPICE AGENCY SERVICES

Scope

This policy and procedure applies to the skilled nursing facility units of ISVH-B.

Purpose

The purpose of this policy and procedure is to establish clear guidelines for coordination of patient care in situations wherein personnel from a hospice agency are providing on-site care to an ISVH-B skilled nursing resident.

Background

1. Due to the nature of ISVH-B and its mission, a large percentage of our residents require lifelong skilled care and will reside here until death. Providing excellent palliative and supportive care for a dying or rapidly declining resident and providing emotional and spiritual support for the resident's family members are well within the capabilities of ISVH-B staff and attending physicians. In most circumstances, our own staff maintains excellent familiarity and rapport with our residents and their involved family members. This puts our staff in an excellent position to provide palliative care and to assist the families of dying or rapidly declining residents. These services are extended to our residents and their families as a matter of course.
2. There may occasionally arise a situation wherein a dying or rapidly declining resident (or the resident's responsible family member or the resident's attending physician) feels that involving additional hospice agency services is appropriate and desirable for the patient's optimal care. This policy and procedure apply to these situations.

Policy

1. ISVH-B will have a maximum of three (3) hospice agency providers authorized to provide services at the ISVH-B at any time. ISVH-B will select authorized hospice agencies by soliciting applications no less than every two (2) years. The selected hospice agencies must accept the terms and conditions governing the provisions of hospice services at ISVH-B prior to providing services within ISVH-B. The hospice agency shall require all hospice agency personnel providing services within ISVH-B to comply with this policy and procedure and the terms and conditions of service. A copy of the terms and conditions governing hospice services is on file in the business office.
2. For patient safety and care coordination reasons:
 - a. The physician supervising and approving all hospice agency services provided within ISVH- B shall be credentialed to provide services at the ISVH-B and the resident's usual attending physician (including the attending physician's

credentialed on-call coverage physicians) who also supervises all other aspects of the resident's medical care.

- b. The resident's attending physician may not delegate supervision of a resident's medical care to the hospice agency's medical director unless that hospice medical director has been credentialed and approved through ISVH-B's usual credentialing process for physicians providing services within the facility.

Procedure

1. Resident visits and contacts shall be conducted as follows:

- a. The designated hospice agency shall come in for their initial visit with the resident within 24 hours of the referral.
- b. All resident visits and contacts, and all cares provided to a resident by hospice agency personnel (e.g., nursing, social work, and counseling services) shall be legibly documented in the appropriate section of the resident's ISVH-B chart. The appropriate section for all hospice documentation with the exception of the hospice care plan will be under the hospice tab located in the resident's active clinical record. The hospice agency shall provide sufficient information in the clinical record that any member of the care team can immediately review the full chronological record of all hospice care, observations and assessments by reviewing the hospice tab chart section.
- c. The hospice agency shall provide ISVH-B with a written weekly schedule of what services they will provide to the resident, when the services will be provided and by whom. The hospice agency shall ensure that the written weekly schedule is kept in the clinical record under the hospice tab.
- d. For each resident visit, the hospice personnel will verbally check in and check out with the ISVH-B licensed nurse currently assigned to the resident to receive verbal report and share any new resident information identified during the hospice visit.
- e. The hospice agency will coordinate with ISVH-B staff to identify the specific services that will be provided by each entity and this information will be communicated in the coordinated plan of care. The hospice agency must include directives for managing pain and other uncomfortable symptoms in the plan of care. These directives must reflect the hospice philosophy and be based on an assessment of the resident's needs and unique living situation in the facility. The hospice agency

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will revise and update the care plan as necessary to reflect the resident's current status. To accomplish this, the hospice agency will designate a Registered Nurse to coordinate the plan of care with the ISVH-B Registered Nurse Manager responsible for the unit where the resident resides. The hospice agency will locate all care plans under the care plan tab located in the resident's clinical record.

2. All social services, spiritual services, and family support services provided by hospice agency personnel shall be coordinated with, and approved by, ISVH-B social services staff prior to implementation.

3. Any unresolved care coordination issues between ISVH-B personnel and hospice agency personnel which, in the opinion of the appropriate ISVH-B R.N. manager and Director of Nursing Services, present barriers to optimal care of a resident or which are disruptive to the care of other residents shall be reported to ISVH-B's Medical Director. The Medical Director will take necessary action to resolve the issue including, if necessary, requesting that the ISVH-B Administrator cancel the hospice agency's contract and facilitating alternate strategies for the provision of appropriate resident care.

Draft 6/30/10, revised 2/11, 3/11, 4/11

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. Write a physician's telephone order for release of remains to the funeral home.
3. Immediately notify family and/or responsible party as delineated in face-sheet of medical record. (Document discussion in nurse progress notes.)
4. Notify mortuary identified in resident's record. (Document discussion in nurse progress notes; see also post-mortem charting protocol.)
5. If the resident's death was **UNEXPECTED** immediately notify:
 - a. Director of Nursing Services
 - b. Unit RN Manager
 - c. Social Services Director
 - d. Administrator
6. Once the remains have been released and the medical record has been updated, the licensed nurse will place the mortician's receipt in front of the paper medical record. The paper medical record will be placed in the unit clerks work area.
7. The **Unit Clerk** shall notify all the parties listed below via e-mail immediately following notification (or shortly after arrival to work – if death did not occur during normal business hours).
 - a. Administrator
 - b. Director of Nursing Services
 - c. RN Manager
 - d. Dietary
 - e. Laundry/Housekeeping
 - f. Business Office
 - g. Health Information Department
 - h. Social Services Department
 - i. Chaplain
 - j. Activities
 - k. Maintenance Department

12/99, revised 02/03; 2/12, 11/14

POSTMORTEM CHARTING PROTOCOL

Include the following in your postmortem nurse note.

1. Condition of resident when last seen alive (if applicable).
2. Condition of resident when found.
3. Documentation of assessment to determine death. (i.e. Apical Pulse for 1 minute, respirations for 1 minute, blood pressure, corneal reflex, pupil size and reaction.)
4. Obtain/write physician order to release body.
5. List people notified, result.
6. Complete Death/Discharge record and give a copy to the mortician. (Disposition of resident's belongings, valuable if pertinent, when body released, by whom, and to whom).
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.

Revised 02/03, 10/03, 01/16, 10/17

NURSE AIDE POSTMORTEM CARE CARD

1. Report to licensed nurse by call light or in person.
2. Stay with nurse and resident.
3. Assist with CPR if initiated.
4. If resident is determined to have died, move to private area.
5. Remove all tubes, IV, and Foley as directed by nurse.
6. Wash body if soiled. Handle gently to prevent tissue trauma.
7. Place pad under resident.
8. Dress resident in gown open in the back.
9. Arrange in sleeping position.
10. Cover with clean blanket or sheet as if asleep, do not cover face.
11. Box and label personal possessions keeping aside small keepsakes, valuables, money, wallet, glasses. Bag and place valuables in med room.
12. Determine if teeth and glasses should be sent with the resident. If so, place on bed under cover by shoulder.
13. Assist with mortician as requested to transfer body to gurney.
14. 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 02/03, 04/16

Accident/Incident Investigation

Resident: _____ Date: _____

Policy Statement: All accident/incidents shall be investigated immediately following the event.

Directions: This accident/incident investigation shall not be made part of the resident's medical record. This document is part of this facilities' Continuous Quality Performance Improvement Program. Information obtained through this investigation should be used to revise the residents plan of care.

Time & Services	
Day of week:	Call light in reach? <input type="checkbox"/> Yes <input type="checkbox"/> No
Time of day:	Call light on? <input type="checkbox"/> Yes <input type="checkbox"/> No
Time last seen by staff:	Res. Able to request help? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was resident incontinent?	Water available/in reach? <input type="checkbox"/> Yes <input type="checkbox"/> No
Investigation	
What was resident doing when event occurred?	
<input type="checkbox"/> Self ambulating	<input type="checkbox"/> Sitting in w/c or chair
<input type="checkbox"/> In bed	<input type="checkbox"/> Self transferring to: Bed ___ W/C ___ Toilet: ___ Other: _____
<input type="checkbox"/> Reaching up for something	<input type="checkbox"/> Attempting to rise from sitting position
<input type="checkbox"/> Reaching down for something	<input type="checkbox"/> Other (describe)
Cognitive Status	
<input type="checkbox"/> Oriented/no problem	<input type="checkbox"/> Inability to understand
<input type="checkbox"/> Confused/disoriented	<input type="checkbox"/> Agitated/Angry
<input type="checkbox"/> Poor safety awareness/judgement	<input type="checkbox"/> Chooses not to request assistance
<input type="checkbox"/> Other (describe)	
New change in cognitive status prior to event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Change in medical condition or medications? (I.e., S/S f UTI, Constipation, hypo/hyper glycemcic) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Can changes be made to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Environmental Issues	
Floor/surface: <input type="checkbox"/> Wet/slippery <input type="checkbox"/> Glare/highly polished <input type="checkbox"/> Powdered <input type="checkbox"/> Loose rug, thick pile <input type="checkbox"/> Uneven surface <input type="checkbox"/> Threshold greater than ½" <input type="checkbox"/> Change in surface: e.g. carpet to tile <input type="checkbox"/> Cluttered, poorly arranged furniture <input type="checkbox"/> No hazards noted Clothing/Shoes <input type="checkbox"/> Item hung or tripped the resident <input type="checkbox"/> Shoes appropriate, fit well/non-skid <input type="checkbox"/> Loose slippers <input type="checkbox"/> Walks in stocking feet <input type="checkbox"/> Gown slippery/silky <input type="checkbox"/> Clothing too tight/fit poorly <input type="checkbox"/> No problems noted Noise: <input type="checkbox"/> Background sounds/noisy/busy <input type="checkbox"/> Startled <input type="checkbox"/> No problem	Lighting: <input type="checkbox"/> Glare <input type="checkbox"/> Inadequate/dark <input type="checkbox"/> Too bright <input type="checkbox"/> No problem Bed: <input type="checkbox"/> Height inappropriate: Low ___ High ___ <input type="checkbox"/> Width inappropriate <input type="checkbox"/> Wheels unlocked/bed moved <input type="checkbox"/> Side rails: x2 ___ x1 ___ full ___ ½___, ¼___, grab bar ___ <input type="checkbox"/> Mattress has gaps <input type="checkbox"/> Surfaces has edges, needs repair <input type="checkbox"/> No problem noted Alarms: <input type="checkbox"/> Sounding <input type="checkbox"/> attached, functioning as expected <input type="checkbox"/> resident removed alarm <input type="checkbox"/> Not attached/turn off, malfunction, etc. <input type="checkbox"/> NA, none ordered Explain if not sounding:

Accident/Incident Investigation & Summary (Cont.)

Resident: _____

Time last pain med given: _____ Date last bowel movement: _____ If Diabetic, what was BG: _____ Oxygen SAT: _____ Time last sleeper: _____ Time last antianxiety: _____	Fall from Wheel Chair: <input type="checkbox"/> 1 brakes locked <input type="checkbox"/> 2 brakes locked <input type="checkbox"/> 0 brakes locked <input type="checkbox"/> 1 foot rest on <input type="checkbox"/> 2 foot rests on <input type="checkbox"/> No foot rest <input type="checkbox"/> Cushion slid out <input type="checkbox"/> Other (explain):	Other: <input type="checkbox"/> W/C or walker contributed <input type="checkbox"/> Restraint contributed <input type="checkbox"/> Mechanical lift contributed <input type="checkbox"/> Adaptive equipment contributed If any above checked, describe:
--	---	---

Adaptive Equipment Currently in Use:

<input type="checkbox"/> Wheel chair	<input type="checkbox"/> Motion alarms
<input type="checkbox"/> Walker	<input type="checkbox"/> Elbow pads
<input type="checkbox"/> Merri walker	<input type="checkbox"/> Hip guards
<input type="checkbox"/> Cane	<input type="checkbox"/> Adaptive call light
<input type="checkbox"/> Side rail _____	<input type="checkbox"/> Transfer bar/pole
<input type="checkbox"/> Air mattress	<input type="checkbox"/> Non-skid rugs
<input type="checkbox"/> Lipped mattress	<input type="checkbox"/> Non-skid socks
<input type="checkbox"/> Geri sleeves/gloves	<input type="checkbox"/> Other (describe):
<input type="checkbox"/> Heel protectors	

Physical State

<input type="checkbox"/> Weak upper body strength	<input type="checkbox"/> Gait unsteady
<input type="checkbox"/> Weak lower body strength	<input type="checkbox"/> Shuffling gait
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Leans forward
<input type="checkbox"/> Non-ambulatory	<input type="checkbox"/> Leans backward
<input type="checkbox"/> Can't bear own weight	<input type="checkbox"/> Unable to maintain sitting position w/o assistance
<input type="checkbox"/> Shaky/jerking movements	<input type="checkbox"/> Slides down in chair/wheelchair
<input type="checkbox"/> Does not understand own physical limitations	<input type="checkbox"/> Other

Other information as indicated:

Care Plan updated:	Date:	Fall Assessment Updated:	Date:
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INCIDENT 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 shall be established to include the Director of Nursing Services, RN Unit Managers, and representation from Social Services, Activities, Restorative Nursing, and any other individuals the members may deem necessary to assist the workgroup.
2. The workgroup shall meet on regularly scheduled intervals to review Incident Report(s).
3. The purpose of the workgroup 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, a report related to the resident's incident will be generated for review at the workgroup.
5. Trending reports related to incidents will be generated and analyzed on a monthly basis (more often when deemed appropriate) for presentation in the QA meeting.

Revised 02/03, 10/03, 03/16

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 report will be initiated for each of the following events:

- Any type of injury to a resident.
- All falls.
- Skin tears and bruises (excluding bruises related to blood draws).
- Resident to resident altercation.
- Resident elopement
- 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 involving a resident shall report the incident directly to the licensed nurse on the specific resident's unit.
2. Accident/Incident Investigation sheet is to be filled out and placed in RNM box.
3. An Incident report in PCC is to be initiated and completed by the attending nurse by end of the shift in which the incident occurred or was reported. (See guidelines for completion of Incident Report.)
4. Immediate interventions identified and/or undertaken as the result of the incident shall be care planned, as appropriate, by the end of the shift in which the incident occurred or was reported. This is to be done by the attending nurse, following consultation with the RN manager.
5. Alert Charting, as appropriate, will be initiated.
6. The RN Manager will report the incident to the Incident workgroup for multidisciplinary evaluation and/or any further interventions.
7. RNM will put a summary result of Investigation in the notes tab of the incident in PCC.

Revised 02/07, 09/08, 03/16, 07/16

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ACCIDENT/INCIDENT INVESTIGATION

ACCIDENT/INCIDENT INVESTIGATION

RESIDENT: _____ DATE: _____ MR# _____

POLICY STATEMENT: All accident/incidents shall be investigated immediately following the event.

DIRECTIONS: This accident/incident investigation shall not be made part of the resident's medical record. This document is part of this facilities' Continuous Quality Performance Improvement Program. Information obtained through this investigation should be used to revise the resident's plan of care.

TIME & SERVICES:	
Day of week _____	Call light in reach? <input type="checkbox"/> YES <input type="checkbox"/> NO
Time of day _____	Call light on? <input type="checkbox"/> YES <input type="checkbox"/> NO
Time last seen by staff: _____	Res. able to request help? <input type="checkbox"/> YES <input type="checkbox"/> NO
Time last offered to toileted: _____	Water available/in reach <input type="checkbox"/> YES <input type="checkbox"/> NO
Was resident incontinent: _____	
INVESTIGATION	
What was resident doing when event occurred? <input type="checkbox"/> Self ambulating <input type="checkbox"/> In bed <input type="checkbox"/> Reaching up for something <input type="checkbox"/> Reaching down for something	<input type="checkbox"/> Sitting in W/C or chair <input type="checkbox"/> Self toileting <input type="checkbox"/> Self transferring to : bed w/c, toilet, other <input type="checkbox"/> Attempting to rise from sitting position <input type="checkbox"/> Other (describe)
COGNITIVE STATUS	
<input type="checkbox"/> Oriented /no problem <input type="checkbox"/> Confused/disoriented <input type="checkbox"/> Poor safety awareness/judgment <input type="checkbox"/> Chooses not to request assist	<input type="checkbox"/> Inability to understand <input type="checkbox"/> Agitated/angry <input type="checkbox"/> Other (describe)
New change in cognitive status prior to event? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes describe:	
Change in medical condition or medications? (ie, S/S of UTI, Constipation, hypo/hyper glyceemic) <input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes describe:	
Can changes be made to medications? <input type="checkbox"/> NO <input type="checkbox"/> YES	
ENVIRONMENTAL ISSUES	
Floor/surface: <input type="checkbox"/> wet/slippery <input type="checkbox"/> glare/highly polished <input type="checkbox"/> powdered <input type="checkbox"/> loose rug, thick pile <input type="checkbox"/> uneven surface <input type="checkbox"/> threshold greater than ½ " <input type="checkbox"/> change in surface: e.g. carpet to tile <input type="checkbox"/> cluttered, poorly arranged furniture <input type="checkbox"/> no hazards noted Clothing and Shoes: <input type="checkbox"/> Item hung or tripped res. <input type="checkbox"/> Shoes appropriate, fit well/non-skid <input type="checkbox"/> Loose slippers <input type="checkbox"/> Walks in stocking feet <input type="checkbox"/> Gown slippery/silky <input type="checkbox"/> Clothing too tight/fit poorly <input type="checkbox"/> No problems noted Noise: <input type="checkbox"/> Background sounds/noisy/busy <input type="checkbox"/> Startled <input type="checkbox"/> No problem	Lighting: <input type="checkbox"/> Glare <input type="checkbox"/> Inadequate/dark <input type="checkbox"/> Too bright <input type="checkbox"/> No problem Bed: <input type="checkbox"/> Height inappropriate low high <input type="checkbox"/> Width inappropriate <input type="checkbox"/> Wheels unlocked/ bed moved <input type="checkbox"/> Side rails: x2 x1 full ½, ¼, grab bar <input type="checkbox"/> Mattress has gaps <input type="checkbox"/> Surfaces has edges, needs repair <input type="checkbox"/> No problems noted Alarms: <input type="checkbox"/> Sounding <input type="checkbox"/> Attached, functioning as expected <input type="checkbox"/> Res. Removed alarm <input type="checkbox"/> Not attached/turn off, mal function etc <input type="checkbox"/> NA none ordered Explain if not sounding:

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ACCIDENT/INCIDENT INVESTIGATION & SUMMARY (CON'T)

Resident: _____ MR# _____

Time last pain med given: _____ Date last bowel movement: _____ If Diabetic what was BG: _____ Oxygen SAT: _____ Time last sleeper: _____ Time last antianxiety: _____	Fall from Wheel Chair <input type="checkbox"/> 1 brakes locked <input type="checkbox"/> 2 brakes locked <input type="checkbox"/> 0 brakes locked <input type="checkbox"/> 1 foot rest on <input type="checkbox"/> 2 foot rest on <input type="checkbox"/> no foot rest <input type="checkbox"/> cushion slid out <input type="checkbox"/> other: explain	Other <input type="checkbox"/> W/C or walker contributed <input type="checkbox"/> Restraint contributed <input type="checkbox"/> Mechanical lift contributed <input type="checkbox"/> Adaptive equipment contributed If any above checked describe:
ADAPTIVE EQUIPMENT CURRENTLY IN USE		
	<input type="checkbox"/> W/C <input type="checkbox"/> Walker <input type="checkbox"/> Merri walker <input type="checkbox"/> Cane <input type="checkbox"/> Side rail _____ <input type="checkbox"/> Air mattress <input type="checkbox"/> Lipped mattress <input type="checkbox"/> Geri sleeves/gloves <input type="checkbox"/> Heel protectors	<input type="checkbox"/> Motion alarms <input type="checkbox"/> Elbow pads <input type="checkbox"/> Hip guards <input type="checkbox"/> Adaptive call light <input type="checkbox"/> Transfer bar/pole <input type="checkbox"/> Non-skid rugs <input type="checkbox"/> Non-skid socks <input type="checkbox"/> Other: describe
PHYSICAL STATE		
<input type="checkbox"/> Weak upper body strength <input type="checkbox"/> Weak lower body strength <input type="checkbox"/> Poor balance <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Can't bear own weight <input type="checkbox"/> Shaky/jerking movements <input type="checkbox"/> Does not understand own physical limitations	<input type="checkbox"/> Gait unsteady <input type="checkbox"/> Shuffling gait <input type="checkbox"/> Leans forward <input type="checkbox"/> Leans backward <input type="checkbox"/> Unable to maintain sitting position w/out assistance <input type="checkbox"/> Slides down in chair/w/c <input type="checkbox"/> Other	
Other information as indicated:		
Care plan updated _____	Date _____	Fall assessment updated _____
		Date _____

RESIDENT-TO-RESIDENT ALTERCATIONS

1. All residents involved in the altercation should be immediately separated and assessed.
2. Following the separation and assessment, the licensed nurse assigned to the residents and/or unit shall:
 - a. Complete an **Incident Report** in PCC for each of the residents involved in the altercation.
 - b. Institute interventions that are appropriate to prevent re-occurrence.
 - c. Immediately **notify** the following:
 1. Family or legal representative for each of the residents involved.
 2. Nursing Home Administrator
 3. Director of Nursing Services
 4. RN Unit Manager
 5. Social Worker assigned to the unit 6). Residents' primary physician.
 - d. Place the residents involved on **Alert Charting**.
 - e. **Document in the Incident Progress Notes in PCC** the following (and any other information pertinent to the incident):
 1. Those involved in the incident e.g. staff, visitors, etc.
 2. The location of the incident and specifics of the area if relevant.
 3. Time of incident.
 4. Events leading up to the incident.
 5. Status of the resident e.g. recent medication changes, changes in health status, etc.
 6. Description of the situation immediately following the incident.
 7. Interventions put into place to prevent reoccurrence.
 8. Staff/family that were notified.
 9. Description of any physical injury and/or emotional status and treatment of the injury (if applicable).
 - f. **Implement care plan.** (Utilize the temporary care plan “Resident to Resident Altercation”)

Revised 8/06, 03/16

RESIDENT INCIDENT WHEN OUT OF THE FACILITY

Purpose:

To provide a process for the assessment of any resident incident that occurred while the resident was being transported in a facility vehicle or during a facility-sponsored outing.

An incident is an unexpected, unintended event that can cause a resident bodily injury such as (but not limited to):

- motor vehicle accident involving the facility vehicle with resident(s) in the facility vehicle;
- fall or injury sustained inside the facility vehicle or while being transferred in or out of the facility vehicle;
- fall or injury sustained during a facility outing; or
- change of condition of a resident anytime in the course of transportation; or
- change of condition of a resident participating in a facility outing.

Procedure:

1. If the incident occurs while the facility vehicle is in motion, the vehicle driver shall pull over to the nearest safe location and assess the situation.
 - a. If the situation appears emergent i.e. heavy bleeding, SOB, chest pain, other acute pain, not breathing, change in level of consciousness, then call 911.
 - i. If 911 is called, then as soon as able facility personnel shall call the facility and speak to a nurse for that residents' unit and inform them of the situation.
 - ii. Should the resident be transported to the emergency department, facility personnel driving the facility vehicle or present at the outing shall identify what hospital resident is being taken to and notify the resident's facility nurse so that appropriate resident paperwork can be faxed to the hospital.
 - b. If the resident appears stable but possibly injured call the facility and speak to the nurse on the unit where the resident resides. Do not move the resident until directed to do so by the nurse. Depending on the circumstances the nurse may direct the facility transport staff to return to the facility, proceed to another medical facility
 - i.e. emergency department or wait until a nurse can come to the vehicle to assist.
2. If the incident occurs during transfer in/out of the facility vehicle or on a facility-sponsored outing.
 - a. If the situation appears emergent i.e. heavy bleeding, SOB, chest pain, other acute pain, not breathing, change in level of consciousness, then call 911.

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- i. If 911 is called, then as soon as able facility personnel shall call the facility and speak to a nurse for that residents' unit and inform them of the situation.
 - ii. Should the resident be transported to the emergency department, facility personnel driving the facility vehicle or present at the outing shall identify what hospital resident is being taken to and notify the resident's facility nurse so that appropriate resident paperwork can be faxed to the hospital.
 - b. If the resident appears stable but possibly injured call the facility and speak to the nurse on the unit where the resident resides. Do not move the resident until directed to do so by the nurse. Depending on the circumstances the nurse may direct the facility transport staff to return to the facility, proceed to another medical facility
 - i.e. emergency department or wait until a nurse can come to the vehicle or outing location to assist.
3. Resident's assigned nurse to complete Incident Report in PCC. (See Procedure for Incident Report completion.)
4. Resident's assigned nurse will immediately notify facility Administrator, Director of Nursing and RN Manager of incident.

10/15, 03/16

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: _____

Hepatitis B Vaccination Tracking

Dose #1: Date _____ Nurse Signature: _____

Dose #2: (1 month later)

Date: _____ Nurse Signature: _____

Dose #3 (6 months later)

Date _____ Nurse Signature _____

Printed Name:

Reviewed 08/14, Revised 5/17, 08/17

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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, urine strips, stool and/or emesis guaiac, influenza A&B, etc.
2. Lab tests performed in the facility can be the result of a physician's order or nursing judgment (no physician's order required).
3. The results of any lab tests performed in the facility (including negative test(s)) shall be documented on the appropriate form and/or in the nurse's notes and/or in the specific resident's eMAR/eTAR.
4. If the results of the tests are documented on a specific lab slip, then the slip shall be placed in the resident's physician's file for review and signature and then filed in the resident's medical record under the lab tab.
5. Results shall also be communicated to the resident's physician for further order(s)/instructions.

Revised: 6/09, 11/14; Reviewed 08/14

ANTIBIOTIC STEWARDSHIP PROGRAM

When a resident in the facility or a resident admitted into the facility has had a recent order for an antibiotic, the following will occur:

1. The Infection Preventionist Nurse shall be notified of an antibiotic order via the Unit Clerk and/or Unit RN Manager.
2. Staff nurse noting an antibiotic order will fill out the Infection Criteria Checklist and put in Infection Preventionist nurses' mail box on the unit.
3. The Infection Preventionist Nurse shall evaluate the use of antibiotics using the “Infection Criteria Checklist” form.
4. The Infection Preventionist Nurse shall evaluate for adverse reactions and/or any newly acquired ABO-related diagnosis.
5. The Infection Preventionist Nurse will report the findings to the Infection Control Committee with the goal of continuous monitoring and reduction of inappropriate antibiotic use.
6. The completed form shall be maintained by the Infection Preventionist Nurse for further reference as needed.
7. Antibiotic Stewardship (Pharmacy and Therapeutics) to meet quarterly and antibiotic use and trends (antibiogram) reviewed quarterly and actions taken as appropriate.

Revised: 9/09, 11/09, 08/17, 1/18; Reviewed 08/14

INFECTION REPORT AND CRITERIA CHECKLIST

RESIDENT: _____ **ROOM #:** _____

CHECK ALL THAT APPLY:

<p>Site of Infection</p> <p>UTI Indwelling cath. _____</p> <p>Resp. Common Cold _____</p> <p style="padding-left: 20px;">Flu-like illness _____</p> <p style="padding-left: 20px;">Bronchitis _____</p> <p style="padding-left: 20px;">Pneumonia _____</p> <p>GI _____</p> <p>Ear _____</p> <p>Sinusitis _____</p> <p>Mouth & perioral _____</p> <p>Skin _____</p> <p>Blood _____</p> <p>Febrile Illness _____</p> <p>Eye _____</p> <p>Primary blood stream _____</p> <p>Other _____</p>	<p>Date of onset of infection:</p> <p>Did the resident admit with this infection or develop it within 3 days of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, date obtained: _____</p> <p>Source of culture: _____</p> <p>Antibiotic/Tx ordered: _____</p> <p>Is this a repeat or change in antibiotic or treatment for an unresolved infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>Notification</p> <p>Date: _____ Time: _____ Physician: _____</p> <p>Date: _____ Time: _____ Family: _____</p>
<p style="color: red; font-weight: bold; font-size: 1.2em;">BE SURE TO COMPLETE THE SYMPTOMS ON THE BACK OF THIS PAGE!!!</p>	<p>Comments:</p>

RESIDENT: _____ **ROOM #:** _____

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<p>URINARY TRACT INFECTIONS Resident without catheter 3 or more of the following: Resident with urinary catheter in place 2 or more of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Has indwelling catheter <input type="checkbox"/> Urine culture performed (select result) <ul style="list-style-type: none"> ➤ No growth ➤ 1 – 10 organisms/ml ➤ 10 organisms/ml <input type="checkbox"/> Fever or chills <input type="checkbox"/> New or increased pain on urination, frequency or urgency <input type="checkbox"/> New flank or suprapubic pain or tenderness <input type="checkbox"/> Change in character of urine <input type="checkbox"/> Worsening of mental or functional status (may be new or increased incontinence) <input type="checkbox"/> Unable to elicit symptoms due to patient mental status. 	<p>GASTROINTESTINAL INFECTIONS Resident must have one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Two or more loose or watery stools above what is normal within a 24-hour period <input type="checkbox"/> Two or more episodes of vomiting in a 24-hour period <input type="checkbox"/> A stool culture positive for Salmonella, Shigella, E. Coli O157:H7, or Campylobacter or a toxin assay of a GI infection (nausea, vomiting, abdominal pain or tenderness or diarrhea)
<p>RESPIRATORY TRACT INFECTIONS Common Cold Syndromes/Pharyngitis: Resident must have two new signs or symptoms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Runny nose or sneezing <input type="checkbox"/> Stuffy nose (congestion) <input type="checkbox"/> Sore throat, hoarseness, or difficulty swallowing <input type="checkbox"/> Dry cough <input type="checkbox"/> Swollen or tender glands in the neck <p>Influenza-Like Illness: Fever (>38°C/100.4°F) And three of the following during influenza season:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> New headache or eye pain <input type="checkbox"/> Myalgias (muscle aches) <input type="checkbox"/> Malaise or loss of appetite <input type="checkbox"/> Sore throat <input type="checkbox"/> New or increased cough <p>Bronchitis or Tracheobronchitis: (Lower resp. Tract Infection) A negative chest radiograph (or no chest radiograph taken) and 3 of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> New or increased cough <input type="checkbox"/> New or increased sputum production <input type="checkbox"/> Fever (> 38°C/100.4°F) <input type="checkbox"/> Pleuritic chest pain <input type="checkbox"/> New or increased finding on exam (rales, rhonchi, wheezes, bronchial breathing) <input type="checkbox"/> New or increased shortness of breath, respiratory rate >25 per minute, worsening mental status <p>Pneumonia: Two of the signs listed under bronchitis or tracheobronchitis above and chest radiograph demonstrating pneumonia, probable pneumonia or an infiltrate.</p> <p>Ear Infection: Either a physician's diagnosis or drainage from one or both ears (ear pain or redness also required if drainage is not purulent)</p> <p>Sinusitis: Physician's diagnosis</p> <p>Mouth and Perioral Infections: Physician's diagnosis</p>	<p>SKIN AND SOFT TISSUE INFECTIONS Cellulitis/soft Tissue /Wound Infection: Pus at wound, skin, or soft tissue site or four of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever (>38°C/100.4°F) or worsening mental/functional status <p>At the affected site, the presence of new or increasing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heat <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness or pain <input type="checkbox"/> Serious drainage <p>Fungal Skin Infection: Both of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maculopapular rash <input type="checkbox"/> Physician's diagnosis <p>Herpes Simplex and Zoster: Both of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vesicular rash <input type="checkbox"/> Physician's diagnosis <p>Scabies</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maculopapular and/or itching rash and/or <input type="checkbox"/> Physician's diagnosis <input type="checkbox"/> Laboratory confirmation <p>Conjunctivitis: One of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pus from one or both eyes for at least 24 hours <input type="checkbox"/> New or increased conjunctival redness, with or without itching or pain, for at least 24 hours <p>PRIMARY BLOODSTREAM INFECTION Either two or more blood cultures positive for the same organism or a single positive blood culture not thought to be contaminant and one or more of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever (>38°C/100.4°F) on two or more occasions at least 12 hours apart in any 3-day period with no known cause.

INFECTION CONTROL COMMITTEE

Infection control will be monitored by the Infection Control Committee at the Idaho State Veterans Home. This committee consists of the Infection Control Nurse (Chair), Medical Director, DNS, Administrator, Pharmacist, Dietary Services Supervisor, Housekeeping (management represent), and Maintenance Supervisor.

This committee will meet at least quarterly and review areas of concern. Spot checks may be done in specific areas such as tub room, kitchen, laundry or individual units.

All problems dealing with infection control will be forwarded to and followed by this committee. 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.

All areas of infection control, safety and sanitation, and pest control will be discussed. Wellness programs and preventative safety precautions may be agenda items.

Revised: 10/09, Reviewed 08/14

RESIDENT INFECTION TRANSMISSION PREVENTION

GUIDELINES FOR PREVENTING TRANSMISSION OF INFECTIOUS AGENTS

1. Residents who are admitted with an infectious disease and/or acquire an infectious disease during their stay will be referred to the facility's Infection Control Nurse and RN Unit Manager for evaluation for implementation of interventions to prevent the transmission of infectious agents.
2. The Infection Control Nurse, in consultation with the RN Unit Manager, resident's primary physician, and other interested parties e.g. Director of Nursing, Facility Administrator, Medical Director, etc., will determine the most appropriate actions to prevent the transmission of the infectious agent(s).
3. Information that serves as the basis for the decision shall include but not be limited to:
 - a. The Center for Disease Control's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, Appendix A
 - b. The resident's current health status and the resident's and staff's ability to manage the resident's affected environment.
 - c. The least restrictive precautions that promote the individual resident's rights and well-being while trying to prevent and control the spread of infections.
4. Decision will include:
 - a. Resident placement (shared or private)
 - b. Type of isolation/precautions.
 - c. Additional interventions/actions, as deemed necessary.
5. The Infection Control Nurse shall be responsible for the implementation and monitoring of the measures put into place to prevent the transmission of infectious agent(s).

10/09, Reviewed 08/14, 06/17

INFECTION CONTROL SURVEILLANCE

Purpose

To have knowledge of resident infections so appropriate actions/follow-up may be done and to guide prevention activities.

Procedure

1. The Infection Control Nurse shall monitor nosocomial infections by:
 - a. Review of culture reports and other pertinent lab data.
 - b. Nurse consultation and referral.
 - c. Chart review.
 - d. Review of the Infection/Antibiotic log maintained on each of the units.
 - e. Review of the Infection Criteria Checklist initiated on each infection by licensed nurse.
 - f. Follow-up on communicable disease exposure.
 - g. Medical Director Consultation.
 - h. Review of geographic location of infections for potential problems/trends/outbreaks.
2. The Infection Control Nurse shall evaluate results of resident nosocomial infection data and develop a Monthly Nosocomial Infection Summary to include total of all nosocomial infections by unit, by type.
3. Report infections to the District Health Department, as required.

3/00; Revised: 10/09, 08/17; Reviewed 08/14

INFLUENZA VACCINE

Policy

It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and contract workers annual immunization against influenza.

Policy Explanation and Compliance Guidelines

1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against influenza disease in accordance with national standards of practice.
2. 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.
3. Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulating in the facility's geographic area.
4. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved "standing orders".
5. 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.
6. Vaccine Information Statements (VIS) will, as appropriate, be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of the influenza vaccine.
7. 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.
8. Residents, staff members, and contract workers retain the right to refuse influenza immunization.

Revised: 11/08, 08/09, 09/09, 10/09, 11/09, 3/10, 07/14, 09/16, 08/17, 02/18

PNEUMOCOCCAL VACCINE

Policy

It is our policy to offer our residents, 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.
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.
4. The resident/representative retains the right to refuse the immunization. A consent for shall be signed prior to the administration of the vaccine and filed in the individual's medical record (see attached form *Immunization Informed Consent 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 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): PCV13, then PPSV23 one year later.
 - b. Previously received PPSV23 at age ≥ 65 : PCV13 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).

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(*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 received due to medical contraindication or refusal.
9. For employees, documentation related to pneumococcal immunization will be maintained in the employee file.

Revised: 11/08, 08/09, 09/09, 10/09, 11/09, 3/10, 07/14, 09/16, 08/17, 02/18

TETANUS DIPHtherIA- PERTUSSIS (TDAP) VACCINE INFORMATION

It is facility practice that all residents be offered the Tetanus, Diphtheria and Pertussis (Tdap) vaccine on admit. We recommend all residents receive the vaccine unless it is medically contraindicated due to allergy or other medical reason.

The facility practice is that residents and/or their legal representative receive the current CDC vaccine information statement (VIS) and consent to the vaccine prior to administration of vaccine.

The current VIS and consent form will be provided to the resident or their legal representative on admit. Consents must be signed and retained in the medical record before vaccine can be administered.

If the resident or their legal representative have questions, please contact the Infection Control Nurse at (208) 780- 1792.

06/12, 08/14, 09/16

TUBERCULOSIS CONTROL PLAN

Employees/Volunteers

All employees/volunteers shall be screened for presence of infection with M. Tuberculosis using the Mantoux PPD skin test. Employees will be tested upon hire. Volunteers will be tested when volunteer hours begin.

1. Employees/volunteers 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/volunteers in need of a current (within one year) PPD skin test shall utilize the form in their orientation packet.
 - b. Employees/volunteers may obtain the PPD skin test from the Infection Control nurse or a licensed nurse on any Unit.
 - c. Employees/volunteers obtaining the PPD skin test must have the test read by a licensed nurse and results documented on the appropriate form between 48 and 72 hours.
 - d. Employees/volunteers will then submit the completed form to the facility's Human Resource Department or Staff Development Coordinator or designated representative for tracking and follow-up, as needed.
2. For purposes of interpretation, a skin test reaction of > 10 mm. 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/volunteer must be received within one week of positive PPD result.
3. Employees/volunteers with a documented history of a positive PPD will not undergo skin testing. Employees/volunteers will, however, complete the Tuberculosis Assessment form and return it to the facility's Infection Control Nurse or designated representative for further processing.
4. Employees/volunteers 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

1. Residents shall be screened for infection with M. Tuberculosis on admission.
 - a. PPD testing shall consist of a Mantoux skin test using 5 units of PPD injected intracutaneously.

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- 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 will employ the two-step procedure.
 - i. If the reaction to the initial PPD test is < 10 mm. a second test will be given 7-14 days later. a). A positive second test is indicative of a boosted reaction and NOT a new infection. b). 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 individual resident's treatment sheet 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.

Revised: 06/13, Reviewed 08/14

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.
1. Follow-up PPD skin test in 10-12 weeks.
2. If results of the test are positive, chest x-ray will be obtained.
3. 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 infectivity.
 - b. Residents who convert shall be evaluated by the resident's physician for active tuberculosis.
4. 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.
5. Any such resident suspected or known to have active pulmonary tuberculosis shall be immediately discharged.
6. Residents requiring transport while considered infectious with tuberculosis shall be provided with a standard surgical mask for the containment of respiratory secretions.

3/00, Revised: 10/03, 08/14

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.)

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 Staff Development Coordinator 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: _____

Reviewed 08/14, 03/17

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 dose 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 08/14

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: _____

Hepatitis B Vaccination Tracking

Dose #1: Date _____ Nurse Signature: _____

Dose #2: (1 month later)

Date: _____ Nurse Signature: _____

Dose #3 (6 months later)

Date _____ Nurse Signature _____

Printed Name:

Reviewed 08/14, Revised 5/17, 08/17

INFORMATION ON HEPATITIS B AND THE VACCINE

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.cdc.gov/viz.
Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.cdc.gov/viz.

1 Why get vaccinated?

Hepatitis B is a serious disease that affects the liver. It is caused by the hepatitis B virus. Hepatitis B can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

Hepatitis B virus infection can be either acute or chronic.

Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. This can lead to:

- fever, fatigue, loss of appetite, nausea, and/or vomiting
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements)
- pain in muscles, joints, and stomach

Chronic hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to:

- liver damage (cirrhosis)
- liver cancer
- death

Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves. Up to 1.4 million people in the United States may have chronic hepatitis B infection. About 90% of infants who get hepatitis B become chronically infected and about 1 out of 4 of them dies.

Hepatitis B is spread when blood, semen, or other body fluid infected with the Hepatitis B virus enters the body of a person who is not infected. People can become infected with the virus through:

- Birth (a baby whose mother is infected can be infected at or after birth)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Each year about 2,000 people in the United States die from hepatitis B-related liver disease.

Hepatitis B vaccine can prevent hepatitis B and its consequences, including liver cancer and cirrhosis.

2 Hepatitis B vaccine

Hepatitis B vaccine is made from parts of the hepatitis B virus. It cannot cause hepatitis B infection. The vaccine is usually given as 3 or 4 shots over a 6-month period.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age.

All **children and adolescents** younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is recommended for unvaccinated **adults** who are at risk for hepatitis B virus infection, including:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, or diabetes
- Anyone who wants to be protected from hepatitis B

There are no known risks to getting hepatitis B vaccine at the same time as other vaccines.



3 Some people should not get this vaccine

Tell the person who is giving the vaccine:

- **If the person getting the vaccine has any severe, life-threatening allergies.**
If you ever had a life-threatening allergic reaction after a dose of hepatitis B vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If the person getting the vaccine is not feeling well.**
If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis B vaccine do not have any problems with it.

Minor problems following hepatitis B vaccine include:

- soreness where the shot was given
- temperature of 99.9°F or higher

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-4636 (1-800-CDC-INFO) or
 - Visit CDC's website at www.cdc.gov/vaccines

Vaccine Information Statement Hepatitis B Vaccine

7/20/2016

42 U.S.C. § 300aa-26

Office Use Only



NOVEL CORONAVIRUS PREVENTION AND RESPONSE

Policy:

This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus.

Definitions:

“**Coronavirus**” is a virus that causes mild to severe respiratory illness.

“**COVID-19**” (short for coronavirus disease 2019) is a new respiratory disease caused by a novel (new) coronavirus that was first identified during an investigation into an outbreak in Wuhan, China. Because it is new, much is still to be learned about the virus. What is currently known is that it is spread person-to-person, mainly between people who are within 6 feet of one another through respiratory droplets produced when an infected person coughs or sneezes.

Policy Explanation and Compliance Guidelines:

1. The Infection Preventionist will assess facility risk associated with COVID-19 through surveillance activities of emerging diseases in the community and illnesses present in the facility.
 - a. No current risk – the facility will implement interventions for prevention and prepare for a potential outbreak.
 - b. Threat detected – the facility will respond promptly and implement emergency and/or outbreak procedures.
2. Staff shall be alert to signs of COVID-19 and notify the resident’s physician if evident:
 - a. Fever
 - b. Cough
 - c. Shortness of breath
3. Staff will “Think COVID-19” when a resident or employee exhibits the following clinical features and epidemiologic risk:

Clinical Features		Epidemiologic Risk
Fever or cough/shortness of breath	AND	Has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever and cough/shortness of breath	AND	A history of travel from affected geographic areas, within 14 days of symptom onset
Fever with severe acute lower respiratory illness (e.g., pneumonia, ARDS) without an alternative explanatory diagnosis such as influenza	AND	No identified source of exposure

4. Considerations/priorities for testing:
 - a. Use clinical judgment on case-by-case basis to determine if a resident has signs and symptoms compatible with COVID-19.
 - b. Test for other causes of respiratory illness, such as influenza or other respiratory panels.
 - c. Consider known community transmission.
 - d. Prioritize symptomatic residents 65 years of age and older and those with underlying conditions that may put them at higher risk for poor outcomes (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, and chronic kidney disease).
5. Interventions to prevent the introduction of respiratory germs into the facility:
 - a. Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection. Restrict visitors in accordance with local, state, and national directives.
 - b. Enforce sick leave policies that allow employees to stay home if they have symptoms of respiratory infection. Follow facility policy regarding work restriction when an employee has an infectious disease.
 - c. Limit points of entry to the facility.
 - d. Consider designated wing/unit or floor to accept new residents.
 - e. Assess residents for symptoms of respiratory infection upon admission to the facility and implement infection prevention practices for incoming symptomatic residents. Inquire of travel history and contact with possible COVID-19 patients.
6. Interventions to prevent the spread of respiratory germs within the facility:
 - a. Keep residents and employees informed by answering questions and explaining what they can do to protect themselves and their fellow residents (i.e. handwashing, spatial separation, respiratory hygiene/cough etiquette).
 - b. Cancel group activities, group therapies, and communal dining.
 - c. Monitor residents for fever or respiratory symptoms.
 - i. Restrict residents with fever or acute respiratory symptoms to their room. Have them wear a facemask if they must leave the room for medically necessary procedures.
 - ii. In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
 - iii. Implement heightened surveillance activities. Report any clusters of respiratory illness or any suspected/confirmed COVID-19 cases within to health department per state/local health department requirements.
 - iv. Restrict employees from work in accordance with current CDC guidelines for health care professionals.
 - d. Monitor staff for fever or respiratory symptoms. Restrict from work and follow current guidance about testing and returning to work (e.g., local health department, CDC).

- e. Support hand hygiene and respiratory/cough etiquette by residents, visitors, and employees by making sure tissues, soap, paper towels, and alcohol-based hand rubs are available.
 - f. Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection.
 - g. Promote easy and correct use of personal protective equipment (PPE) by:
 - i. Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.
 - ii. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room.
 - iii. Position a trash can near the exit inside any resident room to make it easy to discard PPE.
 - h. Consider designating a certain area of the facility for residents with suspected or confirmed cases of COVID-19.
7. Procedure when COVID-19 is suspected or confirmed:
- a. Notify physician, Director of Nursing, Infection Preventionist, and family.
 - b. Place resident in a private room (containing a private bathroom) with the door closed.
 - c. Evaluate the need for hospitalization. If transfer is warranted:
 - i. Arrange for transfer to a facility with the appropriate capacity to manage the resident.
 - ii. Inform ambulance personnel of suspicion of COVID-19 when arranging transportation.
 - iii. Inform staff at transfer location of suspicion of COVID-19.
 - iv. Place facemask on resident for transfer.
 - v. ISVH shall maintain communication with the transfer facility to obtain results of the medical evaluation (i.e. COVID-19 is confirmed or ruled out).
 - d. Limit the number of people who enter the resident's room.
 - e. Notify local health department of suspected or confirmed COVID-19. Follow any instructions.
 - f. Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields, and masks upon entering room and when caring for the resident.
 - g. Restrict resident to his/her room. Place facemask on resident if leaving the room for medically necessary activities.
 - h. Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of care. Clean and disinfect all other equipment used for care.
 - i. Avoid aerosol-generating procedures (i.e. suctioning, nebulizer treatments, and trach care) as possible. If required, take the following precautions:
 - i. Perform in private room (AIIR preferred) with door closed.
 - ii. Wear an approved respirator, eye protection, gloves, and a gown.
 - iii. Limit the number of health care personnel present to essential personnel.
 - iv. Clean and disinfect room surfaces promptly after procedure.
 - j. Cohort residents with COVID-19, if needed, following current CDC guidelines.
 - k. Restrict other residents to their rooms (to the extent possible) except for medically necessary purposes. If they leave their room, have them wear a facemask, perform

- hand hygiene, limit movement in the facility, and perform social distancing (efforts are made to keep them at least 6 feet away).
8. Environmental infection control:
 - a. Immediately disinfect items soiled with blood and other body fluids.
 - b. Housekeeping staff shall adhere to transmission-based precautions.
 - c. Perform routine and terminal cleaning using disinfectants known to be effective against emerging viral pathogens or novel coronavirus SARS-CoV-2 (EPA List N agent).
 9. Implement procedures to identify and monitor others who may have been exposed if COVID-19 disease is confirmed.
 10. Managing a resident who has been treated for COVID-19 illness:
 - a. Verify treatment was completed and the treatment plan for ongoing therapeutic support.
 - b. Utilize transmission-based precautions as determined for the individual when caring for the resident (in collaboration with local health department). Utilize a test-based strategy when determining the duration of transmission-based precautions:
 - i. Resolution of fever, without use of antipyretic medication, **and**
 - ii. Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - iii. Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens). Unless otherwise directed by local health department.
 - iv. Note: Consider other conditions that would require specific precautions (e.g., TB, c. difficile) when determining the duration of transmission-based precautions.
 - c. Indicate COVID-19 history on the resident's plan of care and monitor for recurrent symptoms.
 - d. If the resident is transferred or discharged, communicate information related to treatment for COVID-19 to the receiving facility/provider.
 11. Considerations for admitting residents with suspected or confirmed COVID-19:
 - a. Maintain situational awareness of COVID-19 in the community and impact on hospital capacity. Prepare to create separate wings, units, or floors by moving current residents to handle hospital admissions.
 - b. In absence of public health directives or mandates, follow this general guidance:
 - i. If there is no suspected or confirmed COVID-19 cases in the facility, do not admit until the resident has recovered.
 - ii. If the facility currently has suspected or confirmed COVID-19 cases, admit to a private room on transmission-based precautions or cohort in rooms with other COVID-19 patients. Do not admit if the facility is unable to meet the level of care needs or the requirements for transmission-based precautions.

References:

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Added 04/2020

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 sharp's 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:
 - c. Use a needle-recapping device (e.g. stationary cap-holding device); or
 - d. Place the cap on a horizontal surface and use the one-hand scoop method to slide the needle into the cap.
 - e. 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 by housekeeping or central supply for proper disposal.
 - f. Needles, used or unused, may not be discarded into trash receptacles.
 - g. **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; and
 - iv. Notify the infection control coordinator of the incident as soon as practical.
 - v. Refer to procedure “Protocol for Exposure to Blood Borne Pathogens.”

Revised 08/14

HAND HYGIENE

Policy:

Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.

Policy Explanation and Compliance Guidelines:

1. Hand Hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub.
2. Staff will perform hand hygiene when indicated, using proper technique.
3. Hand hygiene technique when using an alcohol-based 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.
4. Hand hygiene technique when using soap and water:
 - a. Wet hands with water. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.
 - b. Apply enough soap to cover all hand surfaces.
 - c. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.
 - d. Rinse hands with water.
 - e. Dry thoroughly with a single-use towel.
 - f. Use towel to turn off the faucet.

Revised: 12/02, 05/06, 01/11, 08/14, 03/15, 06/17, 08/17, 12/18

USING GLOVES

Purpose

To provide guidelines for the use of gloves for resident and employee protection.

1. EQUIPMENT AND SUPPLIES

- a. Gloves
- b. When gloves are indicated, disposable single-use gloves should be worn.
- c. Used gloves should be discarded into the waste receptacle inside the room.
- d. Sterile gloves should be used only in performing sterile procedures (e.g. Foley insertion).
- e. Nonsterile gloves should be used primarily to prevent the contamination of the employee's hands when providing personal cares to the resident and when cleaning contaminated surfaces.
- f. Perform hand hygiene after removing gloves. Gloves do not replace hand hygiene.
- g. 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. WHEN TO USE GLOVES

- a. When touching excretions, secretions, blood, body fluids, mucous membranes or non- intact skin;
- b. When the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc.;
- c. When cleaning up spills or splashes of blood or body fluids.
- d. When handling potentially contaminated items.
- e. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material.
- f. When performing phlebotomy or starting an IV.

3. PROCEDURE GUIDELINES

- a. 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. Do not touch the gloves.
 - iii. Perform hand hygiene.
 - iv. With one hand, grasp a glove by the inside of the cuff. Insert opposite hand into the glove. Leave the cuff turned down.
 - v. Pick up the remaining glove with gloved hand. Insert ungloved hand into the second glove
 - vi. Pull up cuffs.

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- b. Removing gloves:
 - i. Using one hand, pull the cuff down over the opposite hand turning the glove inside out.
 - ii. Discard the glove into a designated waste receptacle.
 - iii. With the ungloved hand, pull the cuff down over the opposite hand turning the glove inside out.
 - iv. Discard the glove and glove package into the designated waste receptacle.
 - v. Perform hand hygiene.

Reviewed 08/14; Revised 08/17, 12/18

SOILED LINEN HANDLING

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.
 - 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. 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.
 - c. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e. g. gowns if soiling of clothing is likely).
 - d. Linen that is likely contaminated with potentially infectious materials will be managed following the transmission based precaution procedure.
2. Housekeeping will transport the soiled linen to be laundered in the large linen bin on wheels.

10/15, 08/17

PROTOCOL FOR EXPOSURE TO BLOOD BORNE PATHOGENS

A blood borne exposure is an exposure to blood or potentially infectious body fluid through:

- Needle stick, puncture or cut by an object through the skin, *or*
 - Direct contact of mucous membrane (eyes, mouth, nasal, etc.), *or*
 - Exposure of broken skin to blood or other potentially infectious body fluids.
1. Immediate treatment for blood borne exposures:
 - a. Needle-sticks, cuts and skin exposures: Wash with soap and water (Do not use bleach).
 - b. Splashes to the nose mouth or skin: Flush with water.
 - c. Splashes to the eyes: Irrigate with sterile irrigates, saline or clean water.
 - i. Any employee with a significant blood borne exposure should immediately wash or flush the exposed area and be immediately directed to St. Luke’s Emergency Dept. or Occupational Health services for assessment and treatment.
 - ii. All exposures require reporting to the Director of Nursing Services and completion of an employee incident/accident report.
 1. 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.
 2. Lab result records will be maintained in the specific employee’s medical file.
 3. Affected employee will be informed regarding recommendations for Hepatitis B prophylaxis.
 2. 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: 10/03; 7/12, Reviewed 08/14

HEPATITIS B PROPHYLAXIS FOLLOWING PERCUTANEOUS OR PERMUCOSAL EXPOSURE

<i>Exposed Person</i>	<i>HBsAg Positive</i>	<i>HBsAg Negative</i>	<i>Source not tested or unknown</i>
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 HB vaccine series	No treatment	High risk source may treat as if revaccination source were HBsAg positive
Response unknown	Test exposed for anti- HBs:	No treatment	Test exposed for anti- HBs:
	If adequate, no treatment		If adequate, no treatment
	If inadequate,** initiate HB vaccine booster dose		If inadequate, HBIG x 1 plus one revaccination series

*Hepatitis B Immune Globulin (0.6 ml/kg IM)

**Adequate anti-HBs is ≥ 10 mIU/ml

BIOHAZARD SPILL KITS

On each unit, a biohazard spill kit will be kept in the medication/pharmacy room and in a locked cabinet in the soiled utility room.

If a large biohazard spill occurs (nose bleed, GI bleed, vomit, etc.) obtain kit, apply personal protective equipment and follow the instructions provided in the kit for cleaning up biohazardous spills. After cleaning up spill, discard red bagged waste in appropriate container for infectious waste according to CDD/OSHA recommendations. Request replacement kit for unit from Central Supply.

Report to licensed Nurse/Unit Manager.

Revised 10/13, 08/17

STANDARD PRECAUTIONS

Purpose

It is the intent of this facility that:

- All resident blood and body fluids will be considered potentially infectious
- Standard Precautions are indicated for all residents.

BARRIERS INDICATED IN STANDARD PRECAUTIONS

1. Gloves - 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. Amniotic, cerebral spinal, pericardial, pleural, peritoneal, synovial fluids
 - j. Performing venipuncture or invasive procedures
2. Masks/Masks with face shields - should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids.
3. Gowns/Aprons - should be worn when there is potential for soiling clothing with blood/body fluids.
4. Hand hygiene – refer to hand hygiene procedure.

Revised: 09/08, 5/13, 08/17

CONTACT PRECAUTIONS

Purpose

It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Extent of precautions will be determined by the infection control nurse in consultation with the facility's medical director and based on the resident's current health status and staff's ability to manage the resident's affected environment. Interventions related to contact precautions will be outlined in the specific resident's plan of care.

BARRIERS INDICATED FOR CONTACT PRECAUTIONS

Resident Placement

Resident may be placed in a private room. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement.

If a private room is not necessary, the resident may be placed in a room with other resident(s) if the infection is contained e.g. wound dressing, urinary catheter and if the resident is able to assist in maintaining containment of the infection.

Gloves and Handwashing

1. Gloves should be worn when entering the room and while providing care for a resident.
2. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
3. Gloves should be removed before leaving the resident's room and hands should be washed immediately.
4. After glove removal and hand washing, hands should not touch potentially contaminated environmental surfaces or items.

Gowns

1. A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent or wound drainage is not contained by a dressing.
2. If a gown is worn, it should be removed before leaving the resident's room.

Activities

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.
3. Strict hand washing with soap and water by residents and staff in cases of *Clostridium difficile* (C- diff.) infections are indicated.

Equipment

1. Dedicated equipment (stethoscope, blood-pressure cuff, temperature probe, etc.) should be considered for the resident.
2. If use of common equipment or items is unavoidable, the items should be adequately disinfected before use for another resident. To disinfect equipment, wipe with a disinfecting wipe, leave on for 2 minutes then wipe off with a clean dry cloth.
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 a 1:10 dilution of sodium hypochlorite and allow to air dry.

Recommendations:

1. Infections with resistant and/or highly contagious organisms such as MRSA/VRE and C-diff. should be evaluated and treated/isolated on a case-by-case basis.
2. Strict isolation of residents colonized with resistant organisms such as MRSA/VRE is not indicated under most circumstances.
3. Colonization with resistant organisms such as MRSA/VRE is neither an indication for hospitalization nor a reason to restrict admission to a long-term care facility.

02/05; Revised 09/08, 10/09, 5/13, 3/15, 08/17

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 control nurse in consultation with the facility's medical director and based on the resident's current health status, and staff's ability to manage the resident's affected environment. Interventions related to droplet precautions will be outlined in the specific resident's plan of care.

BARRIERS INDICATED FOR DROPLET PRECAUTIONS

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 resident's coughing, sneezing, or during the performance of procedures, e.g. suctioning.

Resident Placement

1. Resident may be placed in a private room.
2. When a private room is not available, maintain spatial separation of at least 3 feet between the infected resident and other residents and visitors.
3. Special air handling and ventilation are not necessary, and the door may remain open.

Gloves and Handwashing

1. Gloves should be worn when entering the room and while providing care for a resident.
2. Gloves should be changed after having contact with infective material (e.g. fecal material and wound drainage).
3. Gloves should be removed before leaving the resident's room and hands should be washed immediately.
4. After glove removal and hand washing, hands should not touch potentially contaminated environmental surfaces or items.

Gowns/Protective Footwear

1. A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent or wound drainage is not contained by a dressing.
2. If a gown is worn, it should be discarded before leaving the resident's room.
3. In addition, protective footwear should be put on prior to entering the room and discarded before leaving the resident's room.

Activities

1. Limit the movement and transport of the resident. If transport is necessary, masking the resident when he/she is out of the room may minimize dispersal of droplets.

Equipment

1. Dedicated equipment (stethoscope, blood-pressure cuff, temperature probe, etc.) should be considered for the resident.
2. If use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident. To disinfect equipment, wipe with a disinfecting wipe, leave on for 2 minutes then wipe off with a clean dry cloth.

Recommendations

1. Infections with resistant organisms such as MRSA/VRE should be evaluated and related/isolated on a case by case basis.
2. Strict isolation of residents colonized with resistant organisms such as MRSA/VRE is not indicated under most circumstances.
3. Colonization with resistant organisms such as MRSA/VRE is neither an indication for hospitalization nor a reason to restrict admission to a long-term care facility.

02/05; Revised: 09/08, 10/09, 5/13

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. Decisions on whether precautions are necessary and when they are no longer necessary will be evaluated on a case by case basis using the 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings Appendix A as a reference.

Placing a Resident on Transmission Based Precautions:

1. A physician's order is required to place a resident on transmission precautions. The order must be specific to the type of isolation – contact, droplet, airborne.
2. Nurse noting order will notify POA/family member of order.
3. Notify Unit Manager, Infection Control Nurse, and Social Services.
4. Notify housekeeping and dietary if resident is confined to room or has limited movement outside of their room).
5. Update the care plan to include specific precautions (refer to Temporary Care Plan; Infection: C-diff, UTI, skin, URI, Pneumonia, etc.).

The instructions below serve as a guideline; modify as needed to suit each resident's needs.

Once the Physician's order has been received:

1. Obtain isolation station and place it on resident's door. These are located in the medical supply room. Ensure isolation station contains the following:
 - a. "Visitors report to Nurses Station before entering room" sign with appropriate color code: yellow for contact isolation, green for droplet isolation, etc. Indicate specific resident room number on the sign with an erasable marker if not a private room.
 - b. Masks with and without face shields
 - c. Gowns – disposable
 - d. Gloves
 - e. Biohazard red trash bags to place in appropriate container (if indicated for regulated waste)
 - f. Biohazard yellow linen bags to place in appropriate container (if indicated for regulated waste)
2. Place isolation specific instructions (i.e. contact, droplet, airborne) in gown pocket of isolation station. Isolation specific signs are found in the nursing forms file at the nurse's station.
3. Use the dedicated isolation equipment box, located in the medication room, which contains a stethoscope, BP cuff and thermometer if indicated.

4. Gather and charge for disposable wound supplies if needed for the resident on isolation (DO NOT over-stock with supplies.) Place charged supplies in a covered plastic container.
 - a. When using the isolation station, once you have gloved and/or gowned, you cannot return to the supply station or med room for forgotten supplies unless you remove gown/gloves, perform hand hygiene, retrieve items and start over with clean gown and gloves.
 - b. 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.
5. 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. blood glucose machine, oxygen monitor.
 - a. Wipe with a disinfecting wipe, leave wet for 2 minutes following manufacturer's directions, wipe off with a clean dry cloth if needed.
 - b. If an item cannot be safely disinfected or if you are unsure, please check with RN Manager, Licensed Nurse, or Infection Control Nurse prior to using.
6. Biohazard trash and linen containers will be initiated by the Infection Control Nurse, DON or Unit Manager if it is determined necessary.
7. 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.
8. 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 biohazard container in the soiled utility room.
 - b. Contaminated Healthcare Linen will be placed in yellow biohazard bags in the appropriate container in resident's room. Nursing staff empties the biohazard linen in resident's room every shift and as needed by placing the yellow bagged biohazard linen in the soiled linen cart in the soiled linen room.
9. For residents on precautions dining in their room, refer to: Isolation Meals Procedure.

Removing a Resident from Transmission Based Precautions:

1. Obtain physician's order to take the resident off isolation. Notify pertinent parties i.e.: Housekeeping, SDC/ Infection Control Nurse, Unit Manager, Dietary, etc. as appropriate.
2. Discard all disposable supplies and wound supplies that are in the resident's room.

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3. 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.
4. Wipe down isolation station with EPA registered disinfecting wipe, restock with basic supplies and store in the Medical Supply room.
5. Regulated Waste and Contaminated Healthcare Linen Instructions:
 - a. Close red isolation trash bag by tying in single knot, close and tape top and bottom flaps of box with 2-inch-wide packing tape and notify housekeeping to pick up taped box from resident's room.
 - b. Close yellow linen isolation bag and tie once, place yellow bag in soiled linen cart in soiled utility room. Call housekeeping to pick up empty biohazard box.
6. Licensed nurse will ensure that housekeeping is notified to do terminal cleaning of resident's room and change out privacy curtain as soon as Transmission Precautions are d/c'd.
7. Update residents care plan.

Revised: 09/08, 10/09, 11/09, 12/12, 6/2013, 08/14, 9/15, 02/17, 6/17

Reference: CDC (2007), Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved 5/21/13 from <http://www.cdc.gov/hipac/pdf/isolation/Isolation2007.pdf>

EXTENDED USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

Purpose: This document offers a strategy or option to optimize supplies of PPE in the facility when there is limited supply.

Facemasks:

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene.
- HCP should leave the patient care area if they need to remove the facemask.

Eye Protection:

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
 - If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- HCP should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

Isolation Gowns:

Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*)

among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.

Strategies to Optimize the Supply of PPE and Equipment. (2020, April 2). Retrieved April 2, 2020, from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

04/2020

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 will 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.

Reference: "Practice Guidance for Healthcare Environmental Cleaning: from the American Society for Healthcare Environmental Services (ASHES).

10/15, 08/17

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 regular dishes, 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 dietary tray and dishes in a red biohazard disposable garbage sack and place on the meal cart to be returned to the kitchen.
6. Dietary staff will clean and sanitize the meal trays returned from isolation wearing personal protective equipment.
7. The nursing staff will inform the Dietary department when a resident is no longer in isolation and regular meal service will resume.

12/12, Revised 5/2013, 08/14

Reference: CDC (2007), Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved 12/12/12 from <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>

REPORTING EMPLOYEE INFECTIONS

Purpose

To insure identification and follow-up of infections among employees.

Procedure

1. Any employee with an infection is responsible for reporting it to the RN unit manager for referral to the infection control nurse.
2. The infection control nurse is responsible for completing and maintaining the employee infection record whenever an infection is reported.
3. The infection control nurse will follow the Center for Disease Control guidelines on work restrictions for communicable diseases. (Refer to Summary of Important Recommendations and Work Restrictions for Personnel with Infectious Diseases.)
4. A physician exam/treatment may be required as appropriate.

Revised: 10/03, 9/09, 10/09, Reviewed 10/15

EQUIPMENT / SUPPLIES CLEANING / DISPOSAL SCHEDULE

1. Urinary drainage bags will be changed on a bi-monthly basis on the **1st** and **15th** of each month. (Dated and Documented on Treatment Sheet)
2. Denture cups will be discarded monthly and re-issued on the **10th** day of each month. (Cups shall be clearly marked with resident's name/date.) (**NOC Shift**)
3. Foley catheters will be changed every 3 (three) months on the 1st of month and PRN malfunction. (Documented on Treatment Sheet).
4. MDI and spacers will be rinsed well with warm water each **Tuesday NOC**.
5. Medication carts/med room are checked on each **NOC Shift** to ensure no expired medications are present.
6. Nebulizers will be changed on Monday of each week and PRN and stored in a plastic bag. (Nebulizers shall be dated and change-over documented on Treatment Sheet.)
7. O2 tubing will be changed on the **1st** of the month and PRN as needed. (Tubing shall be dated and change-over documented on Treatment Sheet.)
8. Pre filled disposable humidifier will be replaced monthly and PRN. (Humidifier bottle will be dated and change-over documented on the treatment sheet.)
9. CPAP/BiPAP/VPAP equipment cleaning (Documented on Treatment Sheet)
 - a. Wash CPAP/BiPAP/VPAP mask daily with unscented baby wipes.
 - b. Wash CPAP/BiPAP/VPAP tubing q week in warm soapy water with baby shampoo. Rinse well and let air dry.
 - c. Wash CPAP/BiPAP/VPAP headgear q week with unscented baby wipes.
 - d. Soak CPAP/BiPAP/VPAP humidifier chamber q week in 1 part white vinegar to 3 parts water for 20 minutes then rinse thoroughly with hot water and air-dry.
 - e. Fill CPAP/BiPAP/VPAP humidifier chamber QHS with distilled water to max fill line.
10. Suction machines in use will utilize disposable canisters, discarded when 2/3 full and after each individual resident use. Tubing/suction catheter will be changed bi-monthly on the **1st** and **15th** of each month, if ongoing use. (**NOC Shift**) (Tubing shall be dated and change-over documented on Treatment Sheet.)
11. Tube feeding pole and pump will be cleaned weekly (**NOC**) and PRN and documented on Treatment Sheet.
12. Tube feeding syringe, bag, tubing, and graduated cylinder will be dated and changed on a **daily** basis (**NOC shift**).
13. Urinals will be **discarded monthly** and re-issued on the **20th** day of each month. (Urinals shall be clearly marked with resident's name/date.) (**NOC shift**)
14. Urine/stool specimen hats shall be marked with the resident's name and will be discarded following use.
15. Water pitchers will be changed each **NOC**.
16. All padding e.g., side rails, pipes, wheelchair arms, etc., will be evaluated for cleanliness and integrity on the **10th** of each month by the **NOC shift**. Results of this evaluation will be communicated to the RN Manager on the unit.

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17. Clean resident's personal electric razor after each use.
18. Wipe down and discard outdated foods/liquids in pantry refrigerator every **NOC Shift**.

11/00; Revised: 10/02, 03/05, 04/06, 05/06, 01/07, 08/07, 10/09, 1/11, 05/15, 11/16, 06/17;
03/18, 05/19 Reviewed 08/14

Reference:

Infection: Prevention and Control of Healthcare-Associated Infections in Primary and Community Care: Partial Update of NICE Clinical Guideline 2, NICE Clinical Guidelines, No. 139, National Clinical Guideline Centre (UK), London: Royal College of Physicians

CLEANING SHARED PERSONAL EQUIPMENT

To prevent the spread of infection and assure that sanitary equipment is used for all residents, all shared personal equipment will be disinfected between each use.

Examples of shared personal equipment that may be used between residents: I-Pods, nail clippers, head phones, etc.

Before and after use of shared personal equipment staff will:

Procedure:

1. Perform hand hygiene.
2. Apply disposable gloves.
3. Wipe down non-porous equipment between each resident use with Germicidal Disinfectant wipes.
4. Allow equipment to air dry per manufacturer's recommendations.
5. Remove and dispose of gloves in trash container.
6. Perform hand hygiene.

09/14, 08/17, 12/18

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RECOMMENDATIONS & WORK RESTRICTIONS FOR PERSONNEL WITH INFECTIOUS
DISEASES

DISEASE/PROBLEM	WORK RESTRICTIONS	DURATION
Conjunctivitis	Restrict from patient contact and contact with the patient's environment	Until discharge ceases
Cytomegalovirus infection (CMV)	No restrictions	
Diarrheal diseases		
Acute state (diarrhea with other symptoms)	Restrict from resident contact, contact with the resident's environment, or food handling	Until symptoms resolve
Convalescent state, salmonella sp.	Restrict from care of high-risk residents	Until symptoms resolve; consult with local and state authorities regarding need for negative stool cultures
Diphtheria	Exclude from duty	Until antimicrobial therapy completed and 2 cultures obtained >24 hours apart are negative
Enteroviral infections	Restrict from care of infants, neonates, and immunocompromised patients 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 patient contact, contact with the patient's environment, or food handling	Until 7 days after onset of jaundice
Hepatitis B		
Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures	No restrictions unless epidemiologically linked to transmission of infection; refer to state regulations; standard precautions should always be observed	Until hepatitis B e antigen is negative
Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures	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	
Hepatitis C	No recommendation	
Herpes Simplex		
Genital	No restrictions	

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Hands (herpetic whitlow) Orofacial	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high- risk residents	
Human Immunodeficiency Virus	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	
Measles		
Active	Exclude from duty	Until 7 days after the rash appears
Post exposure (susceptible personnel)	Exclude from duty	For the 5 th day after the 1 st exposure through the 21 st day after last exposure and/or 4 days after rash appears.
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		

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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 residents and resident's environment or food handling	Until lesions have resolved
Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism	Until lesions have resolved
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 residents (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 resident contact	Until all lesions dry and crust
Post exposure (susceptible personnel)	Restrict from resident 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.

Revised: 10/09, Reviewed 08/14

URINARY TRACT INFECTION IDENTIFICATION AND INVESTIGATION

Purpose

To determine if appropriate treatment/intervention is in place to prevent and/or treat symptomatic urinary tract infections.

Procedure

Upon initiation of treatment for a symptomatic urinary tract infection, the Infection Control Nurse shall conduct the following:

1. Consult with the resident's primary physician and/or review the medical record to determine if a medical cause is present that might precipitate the occurrence of a urinary tract infection.
2. Determine if the cause of the UTI could have been/or can be prevented by nursing or medical interventions.
3. Review risk factors such as incontinence, hydration, hygiene, catheter use, medications, and assistance with toileting.
4. Review resident's environment and other devices that may have an impact on continence/toileting.
5. Review resident's cognitive and mobility status.
6. Review resident's nutritional status.
7. Review lab values – e.g., renal function, culture bacteria.
8. Determine resident's compliance with toileting, continence interventions.
9. Assess resident's skin conditions that may impact and/or encourage urinary tract infections.
10. Conduct other investigations, assessments, and/or reviews as deemed necessary.
11. If applicable, obtain bladder scans (PVR) to determine if urinary retention is present.

Upon completion of the investigation, the Infection Control Nurse shall consult with members of the Incident/Accident Committee to determine further intervention/care planning and to document such findings in the medical record, as appropriate.

11/05; Revised: 08/07, 10/09, 08/14

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: Use silicone based
 - c. Monitoring equipment: ECG electrodes – Conmed, Cleartracce.
 - d. Gloves: Vinyl and Nitrile gloves
 - e. Our Syringes are latex-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

2/10, Reviewed 08/14

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-Boise, 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 parries, 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 staff 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:

- 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*. (March 2019 Revision) *Emergency Preparedness* 483.73.
 - a. 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>
 - b. OSHA pandemic guidelines https://www.osha.gov/Publications/influenza_pandemic.html
 - c. CDC- Pandemic Influenza (link: <https://www.cdc.gov/flu/pandemic-resources/index.htm>)
 - d. CDC- Pandemic Influenza Plan- 2017 Update (<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>)

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- e. CDC- <https://www.cdc.gov/mmwr/PDF/rr/rr4305.pdf>
- f. CDC- Long-Term Care and other Residential Facilities Pandemic Influenza Planning Checklist (<https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>)

- 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. OSHA pandemic guidelines https://www.osha.gov/Publications/influenza_pandemic.html
- d. CDC- Pandemic Influenza (link: <https://www.cdc.gov/flu/pandemic-resources/index.htm>)
- e. CDC- Pandemic Influenza Plan- 2017 Update (<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>)
- f. CDC- <https://www.cdc.gov/mmwr/PDF/rr/rr4305.pdf>
- g. CDC- Long-Term Care and other Residential Facilities Pandemic Influenza Planning Checklist (<https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>)

Added 03/2020

Infection Report and Checklist

RESIDENT: _____ **ROOM #:** _____

CHECK ALL THAT APPLY:

<p>Site of Infection</p> <p>UTI Indwelling cath. _____</p> <p>Resp. Common Cold _____</p> <p style="padding-left: 20px;">Flu-like illness _____</p> <p style="padding-left: 20px;">Bronchitis _____</p> <p style="padding-left: 20px;">Pneumonia _____</p> <p>GI</p> <p>Ear</p> <p>Sinusitis</p> <p>Mouth & perioral</p> <p>Skin</p> <p>Blood</p> <p>Febrile Illness</p> <p>Eye</p> <p>Primary blood stream</p> <p>Other</p>	<p>Date of onset of infection:</p> <p>Did the resident admit with this infection or develop it within 3 days of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, date obtained: _____</p> <p>Source of culture:</p> <p>Antibiotic/Tx ordered:</p> <p>Is this a repeat or change in antibiotic or treatment for an unresolved infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>Notification</p> <p>Date: _____ Time: _____ Physician: _____</p> <p>Date: _____ Time: _____ Family: _____</p>
<p>BE SURE TO COMPLETE THE SYMPTOMS ON THE BACK OF THIS PAGE!</p>	<p>COMMENTS:</p>

RESIDENT: _____

ROOM #: _____

URINARY TRACT INFECTIONS

Resident without catheter 3 or more of the following: Resident with urinary catheter in place 2 or more of the following:

- Has indwelling catheter
- Urine culture performed (select result)
 - No growth
 - 1 – 10 organisms/ml
 - 10 organisms/ml
- Fever or chills
- New or increased pain on urination, frequency or urgency
- New flank or suprapubic pain or tenderness
- Change in character of urine
- Worsening of mental or functional status (may be new or increased incontinence)
- Unable to elicit symptoms due to patient mental status.

GASTROINTESTINAL INFECTIONS

Resident must have one of the following:

- Two or more loose or watery stools above what is normal within a 24-hour period
- Two or more episodes of vomiting in a 24-hour period
- A stool culture positive for Salmonella, Shigella, E. Coli O157:H7, or Campylobacter or a toxin assay of a GI infection (nausea, vomiting, abdominal pain or tenderness or diarrhea)

RESPIRATORY TRACT INFECTIONS

Common Cold Syndromes/Pharyngitis:

Resident must have two new signs or symptoms:

- Runny nose or sneezing
- Stuffy nose (congestion)
- Sore throat, hoarseness, or difficulty swallowing
- Dry cough
- Swollen or tender glands in the neck

Influenza-Like Illness: Fever (>38°C/100.4°F)

And three of the following during influenza season:

- Chills
- New headache or eye pain
- Myalgias (muscle aches)
- Malaise or loss of appetite
- Sore throat
- New or increased cough

Bronchitis or Tracheobronchitis:

(Lower resp. Tract Infection) A negative chest radiograph (or no chest radiograph taken) and 3 of the following:

- New or increased cough
- New or increased sputum production
- Fever (> 38°C/100.4°F)
- Pleuritic chest pain
- New or increased finding on exam (rales, rhonchi, wheezes, bronchial breathing)
- New or increased shortness of breath, respiratory rate >25 per minute, worsening mental status

Pneumonia: Two of the signs listed under bronchitis or tracheobronchitis above and chest radiograph demonstrating pneumonia, probable pneumonia or an infiltrate.

Ear Infection: Either a physician's diagnosis or drainage from one or both ears (ear pain or redness also required if drainage is not purulent)

Sinusitis: Physician's diagnosis

Mouth and Perioral Infections: Physician's diagnosis

SKIN AND SOFT TISSUE INFECTIONS

Cellulitis/soft Tissue /Wound Infection: Pus at wound, skin, or soft tissue site or four of the following:

- Fever (>38°C/100.4°F) or worsening mental/functional status
- At the affected site, the presence of new or increasing:

- Heat
- Redness
- Swelling
- Tenderness or pain
- Serious drainage

Fungal Skin Infection: Both of the following:

- Maculopapular rash
- Physician's diagnosis

Herpes Simplex and Zoster: Both of the following:

- Vesicular rash
- Physician's diagnosis

Scabies

- Maculopapular and/or itching rash and/or
- Physician's diagnosis
- Laboratory confirmation

Conjunctivitis: One of the following:

- Pus from one or both eyes for at least 24 hours
- New or increased conjunctival redness, with or without itching or pain, for at least 24 hours

PRIMARY BLOODSTREAM INFECTION

Either two or more blood cultures positive for the same organism or a single positive blood culture not thought to be contaminant and one or more of the following:

- Fever (>38°C/100.4°F) on two or more occasions at least 12 hours apart in any 3-day period with no known cause.

TUBERCULOSIS (PPD) TESTING – EMPLOYEE / VOLUNTEER

Name

All employees/volunteers will be screened for the 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.)

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 Staff Development Coordinator 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: _____

Reviewed 08/14, 03/17

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NUTRITIONAL RISK REVIEW/NUTRITION INTERVENTION TEAM

Policy

Residents with nutritional concerns will be reviewed by the interdisciplinary team and interventions will be instituted to improve nutritional status. Residents who demonstrate the following conditions will be brought through the IDT meetings as indicated:

- Unplanned significant weight loss or gain
- Open skin ulceration, Stage II or greater pressure injury or non-healing wounds
- Tube feedings
- Weight that is trending down
- Sustained Inadequate oral intake
- Others as determined by the team

Procedure

1. Weights are obtained on each resident on admission and on a weekly or monthly basis based on their assessed needs.
2. All residents with +/- 3# change will be reweighed within 48 hours of the questionable weight.
3. All weights will be reviewed by the charge nurse or designated nursing personnel prior to documenting in the EMR. Weights that are found to be erroneous (based on reweights) will not be documented in the EMR.
4. The unit clerk will enter the weight into each resident's EMR.
5. If a resident is unable to be weighed due to extenuating circumstances, their nutritional status will be monitored using other measures including laboratory review, meal monitoring and progress with wound healing, if applicable.
6. The nutrition committee coordinator (usually dietitian or DSM) reviews weights and meal and fluid documentation each week.
7. The committee coordinator calculates 30-day, 90-day and 180-day weight changes for each resident and compiles a list of residents with significant weight variances. Additionally, residents with undesired downward trends in their weight and/or recent decline in their meal intake or frequent meal refusals should be included on this list.
8. A nutritional risk review committee consisting of at least 3 departments which may include:
 - a. DNS
 - b. RN Manager
 - c. Dietitian
 - d. DSM
 - e. Social Services
 - f. Restorative Nursing Representative
 - g. Rehab. Manager

- h. Wound Nurse
 - i. MDS nurse
 - j. Activities Personnel
 - k. Speech or occupational therapist
 - l. MD
 - m. Administrator
9. Will meet weekly to review the residents identified with nutritional concerns.
10. All residents with unstable nutritional status, will be reviewed by the committee weekly or at a frequency determined by the clinical team based on the resident's needs. If a resident has experienced a weight change that is determined to be strictly due to fluid shifts (changes in edema or large volumes of IV fluids administered prior to admission) and their intake meets estimated needs since admission, a note to this effect can be made in the EMR and the Nutrition Risk Review form in PCC need not be completed.
11. The committee coordinator will provide written communication to the team members at least 1 working days prior to the nutritional risk meeting date. This communication will reflect the meeting date and time as well as the list of residents to be reviewed.
12. For all newly identified residents with nutritional concerns, a Nutritional Risk Review form will be opened in PCC on the same day the written communication is sent to the team members. They will be responsible for completing their section of the form prior to attending the scheduled meeting. Each team member is also asked to come prepared with at least one possible intervention to try for each resident being reviewed. Responsibilities include:
- a. **Nursing/Medical Assessment** section of the form includes a review of any diagnosis or change in medical status that may have an effect on the residents' nutritional status. Areas including fluid retention, pain, positioning, oral status and communication are to be assessed. Each resident should be observed in the dining room prior to coming to the meeting. The comment/intervention section should include a general nursing assessment as well as at least one planned intervention.
 - b. **Social Services Assessment** includes a review of the residents' psychosocial status, being descriptive about any signs of depression, behaviors, etc. that could negatively affect the residents' nutrition. A special focus should be placed on if the resident has medical directives re: nutrition and hydration approaches. A question is included in this section regarding the residents' activities or socialization. The SS personnel should ask the activities personnel to complete this question or should consult with them prior to documenting in this area. The comment/intervention section should include a general assessment of the residents' psychological status as well as at least one possible approach to assist with improved nutritional status.
 - c. **Dietary Assessment** section includes weight data, diet and supplement information, dining services issues, food preferences, calculation of nutrition and hydration requirements and abnormal labs that could indicate a nutritional concern. All residents being assessed should be observed during a meal prior to completing this form and information from that observation recorded in this

section. A general nutritional assessment should be completed at the bottom and at least one planned intervention documented.

13. The team members meet as a group weekly to discuss their respective findings and a team conclusion with interventions is documented in PCC. Additionally, a care plan is developed or updated in PCC to include the nutritional problem, goal and approaches discussed. The team needs to include a discussion of whether a significant change in condition has occurred for the resident and if need be, refer for a new MDS. (A significant change in condition is defined as a change in 2 or more areas – one may be weight loss of 5% in 30 days or 10% in 180 days. Please refer to the RAI manual for further details.) Each team member attending the meeting will have a check mark next to their discipline indicating attendance and participation in the meeting.
14. Each resident reviewed by the committee is followed for a period of time after his or her nutritional status has stabilized, based on the discretion of the team. The Nutritional Risk Review form in PCC is completed weekly allowing for follow up documentation. The follow up review completed for each resident should include a review of the last sessions notes and whether the approaches were successful, current weight and intakes and change from previous review, new medical concerns, new social concerns, at least one new intervention (if the resident is not improving), and when the next review will be completed for this resident. When the committee feels that high-intensity observation is no longer necessary, the resident can be discontinued from the review.
15. The committee coordinator is responsible for:
 - a. Getting the list of residents to the committee members in established timeframes
 - b. Insuring the meeting starts on time and is run efficiently and without interruption
 - c. Assigning duties to be completed during the meeting – to include:
 - i. Documenting on the Nutritional Risk Review form in PCC
 - ii. Keeping minutes and assignments
 - iii. Writing referral forms, fax requests or telephone orders
 - iv. Updating the care plan
 - v. Scanning the weight log, and meal monitor for any items needed
 - vi. Time monitoring (goal 5 minutes per resident)
 - d. Insuring all forms are completed in their entirety
 - e. Reporting to administrator any concerns regarding the committee

Added 09/16

DINING ROOM DUTIES – LICENSED NURSE

Purpose

To define the licensed nurse's responsibility during the dining room meal activity to ensure residents receive accurate and adequate nourishment and hydration.

Procedure

The Licensed Nurse's main duty is to ensure timely delivery of meals and supervise the assistance of meals to those residents that require assistance. The Licensed Nurse assigned to the dining room during meal times shall perform the following and/or ensure that staff performs the following:

1. Ensure all assigned staff are available in dining room at 7:30 am for breakfast, 11:30 am for lunch and 4:30 pm for dinner. If staff are not present, call units. There should be at least five C.N.A.'s and one nurse at each meal.
2. Ensure diet cards are pulled on each resident as they enter the dining room and that residents are served – first come, first served.
3. Circulate to all areas of the dining room to ensure everyone has enough assistance. As independent residents arrive at their tables, assist them with menus, drinks and shirt protectors.
4. Circulate through to the assist tables to ensure there is adequate staff to assist residents and that conditions are safe, and residents are being taken care of.
5. Ensure that residents that can drink by themselves have a beverage. At least one aide should be in the assist area while trays are being served and until the last assist resident leaves the dining table.
6. Ensure that staff are handling food correctly e.g. no touching food, sanitizing after tray passes, not touching eating surfaces of plates or utensils.
7. Ensure residents receive the diet as listed on the diet card and any other assistive devices identified.
8. Do not allow the meal cards to be turned in on the assisted tables until an aide is available to feed at that table. Turn in all the cards at one table at the same time. Once the 1st table has been served, move on to the next table as the aides are available.
9. If you have a lineup of staff waiting to deliver trays it may be possible to pull an aide to one of the assisted tables and start feeding earlier. Keep everyone busy and resident focused.
10. Once the assisted residents receive their trays, circulate the assistance area frequently to ensure residents receive adequate assistance.
11. Ensure staff are conversing with the residents and not among themselves and are feeding residents at eye level.
12. Continue to assist late arriving residents with their menus and tray delivery.
13. You may need to assist with feeding residents if necessary.

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14. Assist in obtaining meal percentages: Do not start gathering meal percentages until at least 50% of the residents have finished their meal.
15. When residents are finished, assign staff to assist residents back to the units so that the others can continue feeding residents. Make sure staff know they are to return to the dining room as quickly as possible to assist another resident back to their room.
16. While circulating: Ensure residents' oxygen is turned on, tank is adequately filled, and residents are positioned appropriately in wheelchair and at the table.
17. Evaluate the dining room environment for safety hazards e.g. spilled fluids, wheelchairs in walkway – remove and correct as possible.
18. Ensure meal percentages and fluid amounts are entered into Point Click Care (PCC).
19. Ensure that residents leaving the dining room following a meal have their shirt protector removed and their face and clothes are clean from food.
20. Communicate any change(s) in resident's status or a resident's need for additional assessment in areas such as increased/decreased assistance with eating/feeding, adaptive equipment, positioning devices, swallowing, meal consistency/texture, etc., to the appropriate RN Unit Manager.

01/07; Revised 06/07, 11/08, 07/09, 01/15, 9/17

ENHANCED MEALS

Purpose

To provide extra calories and/or protein for residents experiencing low body weight, unplanned weight loss, skin issues, or those unable to meet their energy/protein requirements with the food they are consuming.

Procedure

1. Residents will be reviewed periodically by the registered dietician, dietary manager or nutritional at-risk committee. Upon evaluation of their nutritional status, appropriate residents will be placed on the *Enhanced Meal* program. A physician's order will be obtained for all residents receiving this program. The *Enhanced Meal Program* will be identified as *Calorie Enhanced* and/or *Protein Enhanced Program*.
2. The diet card for residents with *Enhanced Meals* will be identified on the resident's diet card.
3. The following approaches will be utilized for all residents identified as needing the *Enhanced Meal* program:
 - a. Calorie Enhanced
 - High calorie breakfast cereal (hot)
 - Half and Half on breakfast cereal (cold)
 - Whole milk at each meal
 - Ice cream on each tray at lunch and dinner
 - Extra margarine or butter used on vegetables/potatoes, as appropriate
 - Other specific approaches, as indicated
 - b. Protein Enhanced
 - At all meals add additional ounce protein (i.e. Egg, cottage cheese, meat, etc.)
 - Other specific approaches, as indicated.
4. The progress of the residents receiving the *Enhanced Meal* program will be evaluated by the RD, dietary manager or nutritional-at-risk committee on a weekly, monthly or quarterly basis. The program will be discontinued upon stabilization of nutritional status.

Revised 10/03, 05/15

GUIDELINES FOR VOLUNTEERS IN THE DINING ROOM

1. Do not serve residents any liquids (beverages, etc.) except what is already on the tray
2. Do not feed the residents
3. If a resident asks for additional or replacement food, drinks, utensils, plates, cups, etc., find out name and notify/get assistance from dietary staff.
4. Place the food and assist to position the residents in a manner that allows easy access to the food. Keep in mind Residents may not have full use of one side of their body, may have vision problems, etc.
5. Be sure to offer assistance to Residents, including cutting up their food, removing covers and lids from food items, putting margarine and jelly on bread, opening cans etc.
6. Be sure shirt protectors are in place if resident desires and are removed before they leave the dining room. ISVH-B nursing staff to place clothing protector on with resident's permission.
7. Do not touch food at any time.
8. Touch utensils only on non-food surfaces (i.e.: only touch forks, spoons & knives on the handles, away from the end that will touch the food).
9. Use hand sanitizer between each tray pass.
10. Place covers over the main dish before carrying trays to Residents.
11. Focus your attention and conversation on the Residents, not on staff. Meals are an important time for Residents.
12. Watch for and report safety hazards such as liquids spilled on the floor.
13. If you are unsure about anything, ask a member of the staff.

7/07, Revised 5/13, 09/16

HYDRATION / NUTRITION

To help ensure residents receive adequate hydration and nutrition:

- a. The licensed nurse shall offer four (4) or more ounces of liquid with each resident's medication pass.
 - b. The licensed nurse shall encourage prune juice as first beverage of choice for a.m. medication pass.
 - c. The licensed nurse shall offer any supplements/liquids, as care planned, between meals and at h.s.
1. As ordered by the resident's physician, liquids, snacks, supplements, shakes, etc., shall be documented as follows:
 - a. Nurse offering item(s) ordered shall initial on the eMAR that the item was offered.
 - b. In addition, the nurse shall document "Y" if the resident consumed the item or "N" if the item was refused, select chart code 9 'other/see progress notes' and progress note findings and document reason for refusal.
 - c. In addition, for purposes of accurate monitoring of hydration/nutrition, if the resident does not consume all of the item(s) ordered/offered it will be considered a refusal and the licensed nurse will document by coding an "N" on the eMAR and select chart code 9 'other/see progress notes' and progress note findings and document percentage of incomplete consumption and reason.

8/08; Revised 01/09, 11/14

RESIDENTS' REFRIGERATOR

Purpose

To ensure safe and sanitary conditions in personal Resident refrigerators.

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.
- The room must have an outlet that the refrigerator can plug directly into. Extension cords of any kind are not allowed for any equipment with a motor.
- 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 and only refrigerators in good condition are allowed.
- The Resident must be capable of obtaining items from the refrigerator independently.
- 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 and discarded when spoiled or outdated.
- Temperature of 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 degree. Refrigerators that malfunction or are in need of maintenance must 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 log sheet will be routed to the Unit Manager at the end of each month and maintained for 3 months.
- Temperatures above 40 degree must be reported to Unit Manager and Social Services and at that time it will be determined if food is safe to be consumed

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or must be discarded. Resident and/or Responsible Party will be notified of the malfunctioning refrigerator and they will be responsible for replacing/repairing if 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.

7/07; Revised 11/09, 05/15, 02/17

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RESIDENT'S DAILY REFRIGERATOR LOG

NOTE: Refrigerator temps greater than 40 degrees or less than 34 degrees must be reported to RN Unit Manager and food moved to appropriate alternate refrigerator.

Resident Name _____ Month/Year _____

Day	Temperature (Fahrenheit)	Comments/ Adjustments	Nurse Initials
1			
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Revised 06/15, 09/16, 02/17

USE AND STORAGE OF FOOD BROUGHT IN BY FAMILY OR VISITORS

It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident.

Policy Explanation and Compliance Guidelines:

1. Family members or other visitors may bring the resident food of their choosing.
2. All food items that are already prepared by the family or visitor brought in must be labeled with resident's name, contents and discard date (three days after delivery).
 - a. The facility may refrigerate labeled and dated prepared items in the pantry refrigerator.
 - b. The prepared food must be in a sealed disposable container or bag that has not been in the resident's room.
 - c. The prepared food must be consumed by the resident within 3 days.
 - d. If not consumed within 3 days, food will be thrown away by facility staff.
 - e. Items placed in the freezer must be labeled with the resident's name and a discard date of no more than 30 days after opening.
 - f. Condiments may be kept until the expiration date or 3 months after opening whichever is first.
 - g. Refrigerator temperatures will be obtained daily to ensure it is between 34 to 40 degrees.
 - h. No alcohol or staff food can be stored in pantry refrigerator.
 - i. The facility will not be responsible for maintaining any reusable items.
3. All food items brought in that are manufactured and does not require refrigeration, may be kept in the resident room inside an air-tight container that is provided by the resident.
4. It is the responsibility of the resident and/or resident representative to maintain said container and items in the container.
5. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative.
6. Any suspicious or obviously contaminated food will be discarded after verbally notifying the resident or responsible party at the discretion of the staff.
7. If any part of this policy is not followed, the facility reserves the right to protect others by not allowing food items to be brought into the facility for a resident.
8. The facility staff will assist residents in accessing and consuming food that is brought in by resident and family or visitors if the resident is not able to do so on their own.
9. If the food item is to be served hot, staff will assist with reheating to >165 degrees (one time only) in the facility microwave oven just prior to serving following safe handling instructions posted.
10. Food preparation and cleaning will follow food safety guidelines.

08/17, 11/17, 08/18

USE OF MICROWAVE OVENS & FOOD THERMOMETERS ON NURSING UNITS

Purpose: To ensure food safety when reheating food on nursing units.

Clean/sanitize the microwave oven before each use with a food-safe disposable sanitizing wipe.

1. Place food to be heated in a microwave-safe dish and lightly cover it with a paper plate or paper towel to avoid splattering during heating.
2. Heat food to appropriate temperatures following Keep Food Safe handling guidelines.
 - a. >165° F for 15 seconds will ensure pathogenic bacteria is killed in all foods, including leftovers.
 - b. Stir food items during microwave heating to ensure even heat distribution.
3. Use a sanitized thermometer (using a sanitizer wipe safe for food service) to check for safe temperatures prior to service.
4. Clean and sanitize the microwave oven and food thermometer after each use.
5. Store sanitized thermometer in holder provided.
6. Supervise/assist resident at risks for burns or who need help to eat (as their care plan directs) to maintain their safety and dignity.

KEEP FOOD SAFE

Be Clean, Be Healthy

- i. Wash hands for 20 seconds with soap and water before and after preparing food
- ii. Do not touch food with bare hands
- iii. Label and date all foods being brought into the facility from the outside with name, contents, and discard date (three days after delivery)

Cook It

- i. Food brought in from outside sources should be heated by a facility staff member
- ii. When microwaving, loosely cover food with a paper plate or paper towel and stir often to heat evenly
- iii. Cook foods to:
 - 165° F for 15 seconds – LEFTOVERS (leftover foods may only be reheated once before discarding)

Throw it Out

- i. When in doubt, throw it out! Food/Beverage with expired manufacturer's dates will be discarded
- ii. All leftover resident foods brought in from the outside should be consumed or discarded within 3 days
- iii. All other fresh/perishable food brought in from outside the facility (opened and/or without a manufacturer's expiration date) should be marked with resident name, contents and current date and should be discarded within 3 days.

11/17

RESIDENT'S DAILY REFRIGERATOR LOG

NOTE: Refrigerator temps greater than 40 degrees or less than 34 degrees must be reported to RN Unit Manager and food moved to appropriate alternate refrigerator.

Resident Name _____ Month/Year _____

Day	Temperature (Fahrenheit)	Comments/ Adjustments	Nurse Initials
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Revised 06/15, 09/16, 02/17

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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, and resident's social worker 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.
 - g. For residents with dementia being considered for an anti-psychotic medication, work in conjunction with the social worker using guidance from the Social Services Policy Procedure titled "Individualized Care & Services for Residents with Dementia and the Use of Antipsychotic Medication in Residents with Dementia."
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 Unit RN Manager (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 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.

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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.

08/06, Revised 03/13, 05/14

PHYSICAL RESTRAINT USE / EVALUATION

Purpose

To ensure this facility utilizes 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 MDS schedule.

Pre-Restraining

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, (see also F Tag 221 for additional restraints) the following interventions should be considered, attempted, and documented as appropriate.

1. Consult with the Unit RN Manager, Rehabilitation Aide, and other nursing and facility staff, as appropriate.
2. Determine if the problem may be caused by:
 - a. Resident's hunger.
 - b. Resident being too hot/cold.
 - c. Resident's need to go to the bathroom.
 - d. Resident looking for someone/something.
 - e. Resident's pain or other medical symptom, i.e., delirium r/t illness such as UTI . . .
3. Need for closer supervision such as:
 - a. Move resident's room closer to the nurses' station.
 - b. Sit resident at nurses' station or with staff members and engage resident in activities of interest to the resident.
 - c. Involve resident in planned activity/social services/pastoral groups as appropriate.
 - d. Increase frequency of rounds and visual checks.
4. Positioning device needed such as:
 - a. Sitting on a couch or in a glider chair
 - b. Gel cushion in a wheelchair
 - c. Non-skid mat on wheelchair seat
 - d. Use of lateral supports in wheelchair
 - e. Use of pillows in bed or elevating head/feet.
 - f. Use of non-skid mat on floor or non-skid socks
 - g. Referral to OT/PT for seating/positioning

5. Need for exercise such as:
 - a. Take resident for walk inside/outside of facility.
 - b. Ambulate as appropriate.
 - c. PT/OT evaluation for strengthening or ambulation program
6. Safety devices such as:
 - a. Visual reminders (flowers at the door, night light, stop signs, yellow tape, etc.)
 - b. Low bed
 - c. Cushion on floor by bedside
 - d. Motion alarms (tag alarms, bed and/or chair alarms)
 - e. Use of watch guard or other safety system
7. Adjust care routines such as:
 - a. Change roommates.
 - b. Change environmental temperature.
 - c. Change mealtimes or offer routine snacks.
 - d. Change bath times/dates.
 - e. Change caregivers.
 - f. Nursing to evaluate the need for a Bowel/Bladder retraining program, or scheduled toileting program, refer to Restorative as appropriate.
8. The results of these interventions should also be documented on the resident's Pre-restraining Assessment in Point Click Care (PCC) Assmnts tab.

Restraint Utilization

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 Unit Manager.)

- a. Complete the Pre-restraining Assessment (Briggs form).
- b. RN Unit Manager to meet with 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:
 1. Type of restraint - be specific.
 2. Reason for restraint use.
 3. 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.
 4. Establish care plan for use of the restraint. (May utilize the Temporary Care Plan for Restraint Use in Point Click Care (PCC) Boise Care Plan Library.
- g. Reflect use of the restraint including type, when to be placed on the resident, etc., on the CNA flow sheet as appropriate.

Restraint Elimination

1. All residents using a “physical restraint” will be continually assessed for possible restraint reduction, as appropriate.
2. Each quarter in conjunction with the MDS schedule and PRN as necessary, the Unit RN Manager shall complete the Physical Restraint Elimination Assessment (Briggs form) and resident will be evaluated by the Physical Restraint/Reduction Review Committee for a physical restraint reduction program implementation.
3. The nursing staff on each unit in conjunction with the committee recommendations, shall implement the restraint elimination interventions.
4. 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 and through documentation on the nursing unit's communication board.
 - 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 CNA flow sheets 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.
5. In the event of a failed restraint reduction:
- a. The unit RN Manager 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, (See Section I, Pre-restraining).

Resident Requests for Restraint Use

1. 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. (See Section I, Pre-restraining).

Revised 10/01, 02/03, 09/14

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, RN Manager from the specific resident's nursing unit, 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.
 - 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 10/01, 02/03, 09/10, 09/14

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POSITION DESCRIPTIONS

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

- Nursing Services Director
- Nurse, Registered Manager
- Staff Development Coordinator
- MDS Coordinator
- Registered Nurse, Senior
- Skin/Wound Nurse
- LPN
- Rehab Nurse
- CNA, Senior
- CAN
- 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 Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Management			65%
Manages staff involved in providing resident care in a skilled nursing environment to include licensed and certified nursing staff.	Yes	Daily	
Interprets and applies laws, rules, regulations, policies and procedures.	Yes	Daily	
Hires, trains and evaluates staff.	Yes	Daily	
Resolves personnel, scheduling and other conflicts.	Yes	Daily	
Monitors budget expenditures	Yes	Daily	
Determines inventory and equipment needs.	Yes	Weekly	
Determines appropriate staffing levels	Yes	Daily	
Ensures staff compliance with existing federal and state regulations, standards of nursing practice and facility policies and procedures.	Yes	Daily	
Reviews and evaluates nursing care operations including facility layout, equipment, employee utilization and work procedures.	Yes	Daily	
Establishes work performance standards.	Yes	Daily	
2. Program Management			15%
Develops and implements facility procedures.	Yes	Weekly	
Identifies program deficiencies and develops appropriate corrective measure.	Yes	Daily	
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	Daily	
Develops reports related to program and staff activities.	Yes	Weekly	
3. Consultation			15%

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Consults with members of the interdisciplinary team to determine appropriate resident care interventions.	Yes	Daily	
Chairs and/or is a member of a variety of facility committees related to facility operations and programs.	Yes	Daily Weekly	
Consults with families, residents, and facility staff in ensuring quality of resident care.	Yes	Daily	
4. Perform other duties as assigned.			5%
Performs other duties as deemed necessary.	Yes	Daily	

Working Environment. This position involves the risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent sitting, standing, bending, stooping, kneeling, squatting, and 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), fin 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.

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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 Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Supervision			30%
Supervises licensed nursing staff and certified nursing aides in the delivery of skilled facility nursing care.	Yes	Daily	
Determines appropriate staffing levels and assigns/reassigns as appropriate.	Yes	Daily	
Evaluates and monitors staff performance.	Yes	Daily	
Provides input into compensation and classification issues.	Yes	Quarterly	
Ensures staff compliance with existing State and Federal regulations and facility policies and procedures.	Yes	Daily	
Counsels employees regarding work performance/expectations.	Yes	Daily Weekly	
Resolves conflicts among staff.	Yes	Daily	
2. Unit Management			50%
Supervises the activities of a unit within the skilled nursing environment.	Yes	Daily	
Oversees/evaluates staff compliance with facility programs.	Yes	Daily	
Monitors/audits and directs timely and appropriate medical record documentation.	Yes	Daily Weekly	
Ensures implementation of new programs, policies and procedures.	Yes	Daily Weekly	
Participates in and evaluates staff related to quality assurance indicators	Yes	Daily Weekly	
Trains staff/distributes information related to facility operations, nursing practices, laws and regulations.	Yes	Daily Weekly	
Consults with families and the medical provider regarding resident care and concern issues.	Yes	Daily Weekly	
Encodes RAI documents and ensures compliance with RAI requirements.	Yes	Weekly	

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Develops/directs the development of individualized resident plans of care and updates as necessary.	Yes	Weekly	
3. Interpersonal Relations/Liaison			15%
Participates in resident care conferences.	Yes	Weekly	
Consults with members of the facility interdisciplinary team to determine appropriate course of action related to resident concerns/plans of care.	Yes	Weekly	
Serves on various facility/department committees as requested.	Yes	Daily Monthly	
4. Perform other duties as assigned			5%
Performs other duties as deemed necessary.	Yes		

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from the 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 and 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.

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IDVS JOB DESCRIPTION - NURSE, REGISTERED MANAGER/MDS COORDINATOR (MED A)

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 Signature:		Date:	
Supervisor Signature:		Date:	
Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Supervision			30%
Supervises licensed nursing staff and certified nursing aides in the delivery of skilled facility nursing care.	Yes	Daily	
Determines appropriate staffing levels and assigns/reassigns as appropriate.	Yes	Daily	
Evaluates and monitors staff performance.	Yes	Daily	
Provides input into compensation and classification issues.	Yes	Quarterly	
Ensures staff compliance with existing State and Federal regulations and facility policies and procedures.	Yes	Daily	
Counsels employees regarding work performance/expectations.	Yes	Daily Weekly	
Resolves conflicts among staff.	Yes	Daily	
2. Unit Management			25%
Supervises the activities of a unit within the skilled care/residential care nursing environment.	Yes	Daily	
Oversees/evaluates staff compliance with facility programs.	Yes	Daily	
Monitors/audits and directs timely and appropriate medical record documentation.	Yes	Daily Weekly	
Ensures implementation of new programs, policies and procedures.	Yes	Daily Weekly	
Participates in and evaluates staff related to quality assurance indicators.	Yes	Daily Weekly	
Trains staff/distributes information related to facility operations, nursing practices, laws and regulations.	Yes	Daily Weekly	
Consults with families and the medical provider regarding resident care and concern issues.	Yes	Daily Weekly	

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3. RAI Process			25%
May initiate the MDS instrument for other disciplines in a timely manner to ensure MDS completion.	Yes	Daily	
Determines if a significant change in condition has occurred and communicates findings to staff to determine appropriate course of action.	Yes	Daily	
Encodes RAI documents and ensures compliance with RAI requirements.	Yes	Weekly	
Develops/directs the development of individualized resident plans of care and updates as necessary.	Yes	Weekly	
May establish a calendar to ensure timely completion of the RAI Process including MDS's, RAPS and care plans.	Yes	Daily Weekly Monthly	
4. Interpersonal Relations/Liaison			15%
Participates in resident care conferences.	Yes	Weekly	
Consults with members of the facility interdisciplinary team to determine appropriate course of action related to resident concerns/plan of care.	Yes	Weekly	
Serves on various facility/department committees, as requested.	Yes	Daily Monthly	
5. Perform other duties as assigned.			5%
Performs other duties as deemed necessary.	Yes		

Working Environment. This position involves the risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from the 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 and 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 – STAFF DEVELOPMENT 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 Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Nursing Management/Leadership			25%
Recruits, interviews, employs and staffs qualified certified nursing assistants (CNA's)	Yes	Daily	
Determines appropriate nursing staffing patterns/levels in consultation with Management staff.	Yes	Daily	
Monitors all nursing staff attendance and reports patterns to the RNM and DNS.	Yes	Daily	
Provides, develops, and implements a supportive orientation program for new and established members of the Department of Nursing, as well as in-house orientation for staff at all levels.	Yes	Weekly Monthly	
Rotates (as necessary) as House Supervisor as well as other duties as identified by the DNS.	Yes	Monthly	
2. Nursing Education			45%
Utilizes the principles of adult learning and teaching, as well as the nursing process to assess, plan, implement, evaluate and monitor the outcomes of quality nursing education in both clinical and classroom instruction that will maintain the highest standards of nursing practice.	Yes	Daily	
Coordinates monthly in-services for the Department of Nursing and any other teaching needs as recognized and/or requested within the facility.	Yes	Monthly	
Attends as necessary, committees to identify educational needs of the staff, residents and family.	Yes	Weekly Monthly	
Participates in the review, development, and teaching of nursing policy and procedures.	Yes	Daily	
Develops monthly in-service calendars for both nursing and the facility.	Yes	Daily Weekly	

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Teaches, adheres to, and advocates the Idaho Nurse Practice Act, the American Nurses Association (ANA) Code of Ethics, and the ANA Social Policy Statement.	Yes	Daily	
Provides both expert clinical education and direct resident care.	Yes	Daily	
Consults with the DNS, Unit Managers, and nursing staff to determine resident acuity/staffing needs and levels.	Yes	Daily	
Produces the necessary educational tools for effective teaching and learning including computer knowledge.	Yes	Daily	
3. Infection Control Nurse			25%
Develops, teaches, implements, reviews, and monitors the infection control program to include maintaining current policies and procedures governing preventions and investigation.	Yes	Daily	
Maintains and manages both employee and resident health care records to include PPD, Hepatitis B, influenza and TB control.	Yes	Daily Weekly	
4. Perform other duties as assigned			5%
Performs other duties as deemed necessary.	Yes	Daily	

Nursing Organizational Goal Attainment

Ability to maintain the philosophy and obtain the goals of the Department of Nursing – an interdependent professional staff that will achieve high standards of clinical practice.
In conjunction with the DNS, recruit and retain competent CAN staff. Supervise and interact with CAN students during on site clinical rotations. Become involved with local colleges, health fairs, CPR training events, health screening and any other activities that will enhance the public’s image of nursing as well as provide visibility for the Idaho State Veterans Home.
Exemplary interpersonal skills that will assist in keeping conflict resolution at the lowest level possible when interacting with staff (at all levels), residents and their families.

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from the 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.

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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 Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. RAI Process			100%
Establishes calendar to ensure timely completion of the RAI process including MDS's, RAP's and care plans.	Yes	Daily Weekly Monthly	
Initiate MDS instrument for other disciplines in a timely manner to ensure MDS completion.	Yes	Daily	
Distributes and updates the MDS calendar on each of the skilled nursing units.	Yes	Weekly	
Communicates time frames to members of the interdisciplinary team.	Yes	Daily	
Completes and signs off on MDS's in accordance with established guidelines.	Yes	Daily	
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	Weekly	
Reviews identified triggers and completes RAPS to identify care plan interventions.	Yes	Daily Weekly	
Communicates care plan needs and revisions to unit RN Managers and other disciplinary staff as appropriate.	Yes	Daily Weekly	
Works with Staff Development Coordinator to implement orientation and ongoing staff training on	Yes	Monthly	

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RAI process including gathering information, assessment of residents, and care plan development.			
Consults with QA Committee to review quality indicators and other factors indicative of care.	Yes	Monthly	
Assists in the development of systems to identify and improve quality of care.	Yes	Weekly	
2. Perform other duties as assigned			5%
Performs other duties as deemed necessary	Yes	Daily	

Working Environment. The position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Frequent sitting.
Occasional squatting, twisting/turning from the 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: <ul style="list-style-type: none"> • 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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Assesses, plans, evaluated, implements and monitors resident health problems and care related issues.			15%
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	Daily	
Conducts admission assessment and initiates admission documentation.	Yes	Weekly	
Oversees delivery of care to residents on the unit.	Yes	Daily	
Ensures staff compliance with governing regulations and facility policies, procedures and practices.	Yes	Daily	
Ensures notification and/or notifies families regarding change in resident status/condition.	Yes	Daily	
Completes program assessments such as fall, AIMS, neurological, skin, etc.	Yes	Daily Weekly	
Responds to resident requests/needs	Yes	Daily	
Refers to other parties/providers as appropriate.	Yes	Daily	
Documents resident behaviors/conditions.	Yes	Daily	
Notifies medical provider regarding resident condition, as appropriate.	Yes	Daily	
Reports to oncoming shift concerns related to resident status, unfinished business and other pertinent data related to unit activities.	Yes	Daily	
Ensures cares are delivered and documented in an appropriate manner and timeframe.	Yes	Daily	
Ensures ordered labs are drawn and transported to lab in a timely manner.	Yes	Daily	
Completes discharge documentation.	Yes	Monthly	
Develops and updates individualized plans of care.	Yes	Daily	

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Performs duties in compliance with Standards of Nursing practice.	Yes	Daily	
2. Staff Supervision/Staffing			25%
Serves as a liaison between nursing units including conflict resolution.	Yes	Daily	
Serves as a resource to other RN's and LPN's related to resident health assessments, medications, treatment interventions and care plan updates.	Yes	Daily	
Assigns, directs, instructs, and evaluates licensed nursing staff and certified nursing staff in patient care delivery on an assigned shift.	Yes	Daily	
Determines appropriate staffing levels, staff assignments, and staff mix in the case of call-ins and 1:1 supervision of unstable residents.	Yes	Daily	
Obtains replacement staff as necessary to accommodate resident and staffing needs.	Yes	Daily	
Coordinates staffing with other floors to maintain minimum staffing levels.	Yes	Daily	
Adjusts employee schedules as necessary to accommodate resident and staffing needs and adjusts staff assignments to provide optimal resident care.	Yes	Daily	
Ensures adequate staffing during resident meals.	Yes	Daily	
Evaluates need for medical assistance for employee related work injuries/illnesses.	Yes	Weekly	
Reviews and signs off on resident care flow sheets.	Yes	Daily	
Approves staff overtime as warranted, documents justification.	Yes	Daily	
3. Documentation			10%
Participates in the facility quality assurance program by assessing program implementation activities and documents findings of these assessments.	Yes	Weekly	
Accurately and completely documents resident assessments and interventions in the medical record.	Yes	Daily	
Documents information r/t <ul style="list-style-type: none"> • Focused charting • Alert charting • Incident reports • Monthly summaries 	Yes	Daily	
Transcribes and notes medical orders.	Yes	Daily Weekly	
May utilize the RAI process.	Yes	Daily	
Provides and documents resident treatments.	Yes	Weekly	
4. Medication/Treatment Administration			35%
Provides and documents resident treatments.	Yes	Daily	

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Dispenses and documents medication administration.	Yes	Daily	
Consults with medical provider and pharmacist regarding medication side-effects, dosages, etc.	Yes	Weekly	
5. Interpersonal Relations			10%
Makes rounds with medical provider to elicit/provide resident-specific information.	Yes	Monthly	
Works with members of the interdisciplinary team to plan problem-specific interventions.	Yes	Weekly Monthly	
Consults with families to apprise of resident condition and to gather pertinent resident care information.	Yes	Daily Weekly	
6. Other Duties as assigned			5%
Performs other duties as deemed necessary.			

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from the 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 and 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 - SKIN/WOUND NURSE

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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:		Date:	
Supervisor Signature:		Date:	
Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Skin Wound Program			15%
Serves as the facility subject-matter expert related to skin and wound issues and wound dressing and healing.	Yes	Daily	
Maintains liaison with VAMC medical and nursing staff related to wound treatment issues, orders and appointments.	Yes	Daily	
Conducts facility in-services related to skin/wound dressing changes (at least quarterly)	Yes	Quarterly	
Completes Skin/Wound QA monitors, as appropriate.	Yes	Daily	
Maintains records of manufacturer's recommended pressure relieving ratings, pressure relieving device supply sources, inventory of facility pressure relieving devices, and other records as appropriate.	Yes	Daily	
Responds to questions from staff, families, physicians, etc. related to skin/wound issues.	Yes	Daily	
2. Skin Breakdown Prevention and Wound Dressing/Healing			80%
Monitors/audits each resident's weekly skin assessment to ensure completeness and accuracy – provides feedback to Unit RN Manager as appropriate.	Yes	Daily	
Conducts comprehensive skin assessment on all new admits and re-admits. Documents results of skin assessment.	Yes	Daily	
Implements appropriate pressure relieving devices to prevent skin breakdown.	Yes	Daily Weekly	
Consults with nursing staff and RN Manager to develop appropriate and specific care plan intervention to prevent skin breakdown.	Yes	Daily Weekly	

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Monitors facility staff to ensure prevention pressure relieving devices are utilized/implemented as care planned.	Yes	Daily Weekly	
Assesses all pressure ulcers on a weekly basis to include: <ul style="list-style-type: none"> • Completes pressure ulcer record • Ensures care plan is in place • Photographs pressure ulcers • Identifies need to request a revision of existing treatment orders related to non-healing status. • Maintains weekly pressure ulcer log/report. • Prepares and submits a monthly skin report to DDNS and Nutrition at Risk committee. 	Yes	Weekly Monthly	
Ensures and/or documents the following activities: <ul style="list-style-type: none"> • Wound assessments documented in the nurse progress notes and/or weekly skin assessments located in the Treatment record. • Care plans developed to reflect current skin/wound status. • ADL flow sheets update/revised to reflect skin/wound interventions. • Treatment sheets reflect current wound/skin status including assessments, dressings, and other monitoring interventions. • Skin/wound activities reported to appropriate nursing staff. 	Yes	Daily	
Reviews incident reports/24-hour report/skin/wound communication book related to resident wounds/skin conditions and conduct follow-up as necessary.	Yes	Daily	
Observes licensed staff changing wound dressing and document performance.	Yes	Daily	
3. Perform other duties as assigned			5%
Performs other duties as deemed necessary.			

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Endurance for frequent standing, walking, bending, stooping.
Occasional squatting, twisting/turning from the waist.
Limited sitting, reaching above shoulder level.
Pushing/pulling objects on rollers/wheels.
Moving objects horizontally (left to right) and vertically (up and down).

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Frequency 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.
Frequency 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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Evaluate and monitor resident health problems and care-related issues.			25%
Assesses health status by collecting, reporting, and recording objective data	Yes	Daily	
Instructs resident/families regarding healthcare related issues.	Yes	Daily	
Ensures direct care staff service delivery.	Yes	Daily	
Notifies families/physician regarding a change in resident status.	Yes	Daily	
Completes program assessments such as fall, AIMS, neurological, skin, etc.	Yes	Daily	
Responds to resident requests/needs.	Yes	Daily	
Documents resident behaviors/conditions.	Yes	Daily	
Reports to oncoming shift concerns related to resident status, unfinished business and other pertinent data related to unit activities.	Yes	Daily	
Updates individualized plans of care and evaluates for effectiveness.	Yes	Daily	
Performs duties in compliance with established standards of nursing practice.	Yes	Daily	
2. Documentation			25%
Documents resident assessments and interventions accurately and completely.	Yes	Daily	
Documents information r/t: <ul style="list-style-type: none"> • Focused charting • Alert charting • Incident reports • Monthly summaries 	Yes	Daily Monthly	
3. Medication/Treatment Administration			35%
Provides and documents resident treatments.	Yes	Daily	

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Dispenses and documents medication administration.	Yes	Weekly	
Consults with medical provider and pharmacist regarding medication side-effects, dosages, etc.	Yes	Weekly	
4. Interpersonal Relations			10%
Works with members of an interdisciplinary team to plan problem-specific interventions.	Yes	Daily	
Supervised direct care staff.	Yes	Daily	
5. Performs other duties as assigned.			5%
Performs other duties as deemed necessary.	Yes	Daily	

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Frequent standing, stooping, kneeling, squatting, bending, twisting turning from the waist.
Pushing/pulling objects on rollers/wheels.
Moving objects horizontally (left to right) and vertically (up and down).
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: <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 – REHAB NURSE

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 Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Supervision			95%
Directs, supervises, coordinates and carries out the Restorative Care program.	Yes	Daily	
Provides staff education and in-service in the restorative care process.	Yes	Daily	
Conducts routine quality assurance evaluations of the program.	Yes	Daily	
Identifies and coordinates the purchase of needed equipment.	Yes	Daily	
Serves as a liaison with physical therapy and other therapeutic staff and contractors.	Yes	Daily	
Screens and identifies resident's needs for restorative programming.	Yes	Daily	
Assists in writing care plans to identify problems, goals and restorative approaches.	Yes	Daily	
Provides ongoing feedback to DNS and Home Administrator.	Yes	Daily	
Ensures that applicable policies and procedures are current and appropriately disseminated.	Yes	Daily	
2. Perform other duties as assigned.			5%
Performs other duties as deemed necessary.	Yes	Daily	

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

Physical Requirements

Frequent standing, stooping, kneeling, squatting, bending, twisting turning from the waist.
Pushing/pulling objects on rollers/wheels.

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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.

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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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Lead Work			10%
Provide resident care training/orientation to certified nursing assistants and other staff as necessary.	Yes	Weekly	
Assist in ensuring staff compliance with facility policies and procedures and state and federal regulations.	Yes	Daily	
Teach self-help skills to residents.	Yes	Daily	
Audit aide flow sheet/resident behavior documentation; /provides input as necessary.	Yes	Weekly	
Serve as a liaison between direct care staff and licensed nursing staff.	Yes	Daily	
Direct resident health care activities.	Yes	Daily	
Provide input into employee evaluations.	Yes	Annually	
May resolve conflicts between direct care staff.	Yes	Weekly	
Serve as a trainer in a structured employee orientation program to include preparing and/or presenting certified nursing aide instructional material.	Yes	Weekly	
Monitors staff performance R/T resident cares.	Yes	Daily	
Coordinate the integration of new staff into unit activities/schedules.	Yes	Weekly	
Consult with interdisciplinary staff to develop/revise training materials.	Yes	Weekly	
2. Patient Care			75%
Answer call lights to determine resident needs.	Yes	Daily	
Obtain and record vital signs.	Yes	Daily	
Provide personal hygiene care including peri-care and bathing activities.	Yes	Daily	
Assist residents with activities of daily living as necessary.	Yes	Daily	
Lift, transfer, reposition, and escort residents.	Yes	Daily	

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Assist residents with ambulation and other body movements.	Yes	Daily	
Feed residents as required.	Yes	Daily	
Responsible for providing direct resident care on a hall/zone.	Yes	Daily	
Provide input into and implement individualized resident care in accordance with standards of practice and resident plan of care.	Yes	Weekly	
Report changes in a residents' condition to licensed nursing staff or other facility staff as appropriate.	Yes	Daily	
Maintain a safe and sanitary resident care environment.	Yes	Daily	
Consult with other staff, as needed, to determine appropriate interventions.	Yes	Daily	
3. Documentation			10%
Observe, report and record resident activities and behaviors.	Yes	Daily	
Audit aide documentation and provide feedback as appropriate.	Yes	Monthly	
4. Miscellaneous and Other Duties as Assigned			5%
Assist in determining appropriate stocking levels for unit supplies, restock/reorder as necessary.	Yes	Daily Monthly	
Provide input into facility operations, policies and procedures.	Yes	Weekly	
Participate on facility committees when appropriate.	Yes	Monthly	
Transport residents to and from the facility as needed.	Yes	Weekly	
Perform other duties as deemed necessary.	Yes	Daily	

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

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 20 lbs., occasionally up to 50 lbs., rarely up to 75 lbs.
Occasional sitting, kneeling, squatting, twisting/turning from the waist, reaching above the shoulder.
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: <ul style="list-style-type: none"> • Ability to hear and talk in quiet/noisy surroundings and talk/hear over the phone.

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- 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: 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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Patient Care			80%
Answer call lights to determine resident needs.	Yes	Daily	
Obtain and record vital signs.	Yes	Daily	
Provide personal hygiene care including peri-care and bathing activities.	Yes	Daily	
Assist residents with activities of daily living as necessary.	Yes	Daily	
Lift, transfer, reposition, and escort residents.	Yes	Daily	
Assist residents with ambulation and other body movements.	Yes	Daily	
Feed residents as required.	Yes	Daily	
Implements individualized resident care in accordance with standards of practice and resident plan of care.	Yes	Daily	
Reports changes in resident condition to licensed nursing staff or other facility staff as appropriate.	Yes	Daily	
Maintains a safe and sanitary resident care environment.	Yes	Daily	
Consults with other staff, as needed, to determine appropriate interventions.	Yes	Daily	
2. Documentation			10%
Observes, reports and records resident activities and behaviors.	Yes	Daily	
3. Miscellaneous			5%
Instructs residents regarding safe transferring skills and other activities of daily living.	Yes	Daily	
Orients new employees, students and volunteers.	Yes	Weekly	
Provides input into facility operations, policies and procedures.	Yes	Weekly	
Participates on facility committees as appropriate.	Yes	Monthly	
Transports residents to and from facility, as needed.	Yes	Weekly	

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4. Bathing (Option)			
Notifies assigned staff and retrieves residents scheduled for bathing/showering.	Yes	Daily	
Ensures bathing process does not interfere with resident activities, therapy, meals or rest periods.	Yes	Daily	
Bathes/showers residents in accordance with standards of care and resident preferences.	Yes	Daily	
Shampoos hair shaves facial hair, trim nails on non-diabetic residents and provides other personal cares as appropriate.	Yes	Daily	
Develops and/or provides input into the development of the unit's bathing schedule.	Yes	Daily	
Maintains current resident bathing schedule.	Yes	Daily	
Maintain daily bathing record and skin assessment information.	Yes	Daily	
Documents bathing activities on each resident's flow sheet, including rationale for refusal, as necessary.	Yes	Daily	
Notifies nurse assigned to a resident immediately upon the discovery of skin wounds, bruises, scrapes or skin tears, rashes or other problems.	Yes	Daily	
Notifies nurse regarding unfinished baths, residents in need of PM or weekend bath, etc.	Yes	Daily	
5. Performs other duties as assigned			5%
Performs other duties as deemed necessary	Yes		

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

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 20 lbs., occasionally up to 50 lbs., rarely up to 75 lbs.
Occasional sitting, kneeling, squatting, twisting/turning from the waist, reaching above the shoulder.
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: <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.

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- Ability to feel size, shape, temperature, texture.
- Ability 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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:	Date:
Supervisor Signature:	Date:

Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Therapy			75%
Implements therapeutic plans of care to include ambulation and range of motion.	Yes	Daily	
Assists residents in activities to promote self-care.	Yes	Daily	
Instructs/encourages resident participation in activities/exercises.	Yes	Daily	
Prepares equipment and ensures availability of supplies.	Yes	Daily	
Assists in the preparation of residents receiving treatment.	Yes	Daily	
Schedules residents for therapy.	Yes	Daily	
Serves as a liaison between therapy and facility staff.	Yes	Daily	
Provides input into individualized resident care planning.	Yes	Daily	
Trains/orients staff in safe transferring techniques and other related therapy activities.	Yes	Weekly	
Observes, records and reports resident progress with therapy activities.	Yes	Daily	
Consults with nursing staff as appropriate regarding resident status/change.	Yes	Weekly	
Provides input into MDS documentation including balance and gait.	Yes	Weekly	
2. Position Devices			10%
Consults with Physical Therapist/Occupational Therapist, assesses resident for current and potential use of positioning devices.	Yes	Weekly	
Communicates resident positioning needs to nursing staff and other interdisciplinary team members, as appropriate.	Yes	Weekly	
Updates resident care plans and ADL flow sheets to reflect positioning device interventions.	Yes	Monthly	

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In-services staff regarding the application and use of positioning devices.	Yes	Monthly	
3. Patient Cares			5%
Obtains and records vital signs.	Yes	Daily	
Provides personal cares related to activities of daily living.	Yes	Daily	
Documents resident activities/behaviors.	Yes	Daily	
4. Miscellaneous			5%
Participates on facility committees, if needed.	Yes	Monthly	
Transports residents to and from facility, as necessary.	Yes	Weekly	
5. Perform other duties as assigned.			5%
Performs other duties as deemed necessary.	Yes		

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

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 20 lbs., occasionally up to 50 lbs., rarely up to 75 lbs.
Occasional sitting, kneeling, squatting, twisting/turning from the waist, reaching above the shoulder.
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: <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

CERTIFIED NURSING ASSISTANT/TRANSPORTATION 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, **with or without** reasonable accommodation. (See HR for information on reasonable accommodation)

Employee Signature:		Date:	
Supervisor Signature:		Date:	
Duties & Responsibilities	Essential Function	Frequency	Percent %
1. Patient Care			25%
Answers call lights to determine resident needs.	Yes	Daily	
Obtains and records vital signs.	Yes	Daily	
Provides personal hygiene care including per-care and bathing activities.	Yes	Daily	
Assists residents with activities of daily living, as necessary.	Yes	Daily	
Lifts, transfers, repositions and escorts residents.	Yes	Daily	
Assists residents with ambulation and other body movements.	Yes	Daily	
Feeds residents as required.	Yes	Daily	
Implements individualized resident care in accordance with standards of practice and resident plan of care.	Yes	Daily	
Reports changes in resident condition to licensed nursing staff or other facility staff as appropriate.	Yes	Daily	
Maintains a safe and sanitary resident-care environment.	Yes	Daily	
Consults with other staff, as needed, to determine appropriate interventions.	Yes	Daily	
2. Documentation			15%
Observes, reports, and records resident activities and behaviors.	Yes	Daily	
3. Miscellaneous			5%
Instructs residents regarding safe transferring skills and other activities of daily living.	Yes	Daily	
May orient new employees, students and volunteers.	Yes	Weekly	

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Provides input into facility operations, policies and procedures.	Yes	Weekly	
May participate on facility committees.	Yes	Monthly	
Maintains a professional appearance and rapport with all medical offices/facilities in the community.	Yes	Weekly	
4. Transportation Aide			50%
Coordinates with Admission Coordinator for new admit and re-admit transports.	Yes	Daily	
Coordinates with nursing unit clerks for daily changes or appointments added to the schedule.	Yes	Daily	
Screens transport calendar daily for conflicts and notifies the unit clerk for amendments/changes when needed.	Yes	Daily	
Keeps Restorative Manager informed of situations as they arise.	Yes	Daily	
Signs for Residential Care medications at VAMC and delivers meds to 2 East.	Yes	Daily	
Ensures that each resident is clean, dressed appropriately and toiled prior to their appointment.	Yes	Daily	
Ensures that residents have had their scheduled medications prior to leaving for their appointments.	Yes	Daily	
Ensure proper outer clothing for the weather conditions.	Yes	Daily	
All residents have the equipment needed for transport: foot pedals on w/c, walker, cane, O2 tank is full and serviceable. Extra change of clothing, incontinent products and wipes are available if needed.	Yes	Daily	
Transport Aide has all appropriate documentation/paperwork needed for the resident's appointment and returns all paperwork to unit clerk when appointment is completed.	Yes	Daily	
Ensures that all residents are accompanied by a staff/family member to appointments as needed.	Yes	Daily	
5. Perform other duties as assigned			5%
Performs other duties as deemed necessary.	Yes		

Working Environment. This position involves a risk of exposure to:

Blood and bodily fluids	Latex	Odors, chemicals
Disease	Hazardous Drugs	TB
Mechanical/Electrical		

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 20 lbs., occasionally up to 50 lbs., rarely up to 75 lbs.

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Occasional sitting, kneeling, squatting, twisting/turning from the waist, reaching above the shoulder.
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: <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.

FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION

1. PURPOSE

Each resident at Idaho State Veterans Home –Boise 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- Boise 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-B requires all employees, managers, supervisors, agent, and contractors to report any reasonable suspicion of crimes committed against a resident. The Idaho State Veterans Home-Boise 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-B 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 Idaho State Veterans Home-Boise 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 resident's 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 Idaho State Veterans Home – Boise. 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-Boise 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-B 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-B 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- B 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-B- 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-B 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 Boise City Police Department (208) 377-6790

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-B 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-B 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-B 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-B 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-B, 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:
 - i. 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 the alleged incident.
 - ii. 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:
 1. Social Services and supervisors will conduct interviews with resident's and any resident witnesses identified in the investigation.
 2. Social Services and supervisors will conduct interviews and obtain 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.
 3. 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, family members.
 4. 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.
 5. 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.

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6. 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 hours may include:
 14. The emotional state of the resident(s).
 15. Any verbal or physical aggression towards others.
 16. Any change in medication.
 17. Any physical changes.
 18. 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, 01/18, 06/19, 02/20

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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 Boise 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 – Boise.</p> <p><u>IDAHO STATE VETERANS HOME CONTACT:</u> Rick Holloway, Administrator 320 Collins Road, Boise, ID 83702 Phone: (208) 780-1600 Fax: (208) 780-1601 Email: rick.holloway@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>BOISE CITY POLICE DEPARTMENT CONTACT: 333 N. Mark Stall Place, Boise, ID 83704 Phone: (208) 377-6790 – Non-Emergency Dispatch (208) 570-6000 – General Information 911 – Emergency General Fax – 570-6732</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>		
INDIVIDUAL[S] REPORTING		
THIS REPORT IS MADE BY THE FACILITY ON BEHALF OF ALL COVERED INDIVIDUALS LISTED BELOW.		
Name:	Date/time individual became aware of suspected crime	
1.	Date: ___/___/___	Time: _____
2.	Date: ___/___/___	Time: _____
3.	Date: ___/___/___	Time: _____
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, 01/18

REASONABLE SUSPICION OF A CRIME AGAINST A RESIDENT REPORTING FORM

INSTRUCTIONS: Contact and submit this completed form to the Bureau of Facility Standards and Boise 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 – Boise.

IDAHO STATE VETERANS HOME CONTACT:

Rick Holloway, Administrator 320 Collins Road , Boise, ID 83702 Phone: (208) 780-1600

Fax: (208) 780-1601

Email: rick.holloway@veterans.idaho.gov

Reported to the State Survey Agency? Yes
 No Date Reported: ___/___/___ Time: _____
BUREAU OF FACILITY STANDARDS CONTACT:
 3232 Elder Street, PO Box 83720, Boise, ID 83720
 Reporting Portal www.ltc-portal.com

Reported to the Local Law Enforcement? Yes
 No Date Reported: ___/___/___ Time: _____
BOISE CITY POLICE DEPARTMENT CONTACT:
 333 N. Mark Stall Place, Boise, ID 83704
 Phone: (208) 377-6790 – Non-Emergency Dispatch
 (208) 570-6000 – General Information
 911 – Emergency General Fax – 570-6732

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 ___)

Resident Name: _____ **DOB:** _____ **SSN#:** _____

Description & Location of Incident:

Was there serious bodily injury as a result of the incident? No ___ YES ___ (must be reported within 2 hours)

INDIVIDUAL[S] REPORTING

THIS REPORT IS MADE BY THE FACILITY ON BEHALF OF ALL COVERED INDIVIDUALS LISTED BELOW.

Name:	Date/Time individual became aware of suspected crime
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3. _____	Date: ___/___/___ Time: _____
4. _____	Date: ___/___/___ Time: _____
5. _____	Date: ___/___/___ Time: _____
6. _____	Date: ___/___/___ Time: _____
7. _____	Date: ___/___/___ Time: _____
8. _____	Date: ___/___/___ Time: _____

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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.

Revised 12/18

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 carried out by the therapist or nurse without assistance from the resident.
 - a. Purpose: To retain as much joint range of motion as possible to maintain circulation.
 - b. Action:
 1. Stabilize the proximal joint and support the distal part.
 2. Move the joint smoothly, slowly and gently through its full range of motion. 3). Avoid producing pain.
2. Active Assistive: An exercise carried out by the resident 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 resident to take the joint actively through its range of motion.
 - ii. Give only the amount of assistance necessary to accomplish the action. 3). Short periods of activity should be followed by adequate rest periods.
3. Active: An exercise accomplished by the resident 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 resident 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 resident 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 resident moves the joint through its range of motion while the therapist provides slight resistance at first and then progressively increases resistance.
 - ii. 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 resident.
- a. Purpose: To maintain strength when a joint is immobilized.
 - b. Action:
 - i. The resident contracts or tightens the muscle as much as possible without moving the joint.
 - ii. He holds for several seconds, then "lets go" and relaxes.
 - iii. He breathes deeply during the contraction phase.

Revised 12/18

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 resident'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 residents 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 resident's clinical status allows such activity.

Techniques of Range of Motion

1. Place resident 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.

InversionMovement that turns the sole of the foot inward.

EversionTurns the sole of the foot outward.

Dorsiflexion.....Flexing or bending the foot toward the leg.

Plantar flexionFlexing or bending the foot in the direction of the sole.

PronationRotating 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.

External: Turning outward, away from the center.

Internal: Turning inward, toward the center.

Revised 12/18

PREVENTING EXTERNAL ROTATION OF THE HIP

Residents 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 resident 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 resident 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 resident 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 resident 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 resident 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 resident's buttocks.
 - g. For the larger resident, a draw sheet or a bath blanket may be used.

Revised 12/18

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 resident 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 resident 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 resident to flex and extend (curl and stretch) his feet and toes frequently.
3. Have the resident rotate ankles clockwise and counterclockwise several times each hour.

Revised 12/18

SUPPORTING THE RESIDENT 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 resident 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).

Resident Objective

To care for himself in his daily routine without depending on others.

Role of the Care Giver

To teach, support and supervise resident while he performs these activities, getting any devices necessary which may help him facilitate these.

Resident 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 resident can do by watching him perform.
4. Encourage the resident 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 resident can tolerate.
8. Have the resident perform and practice the activity in a real-life situation.
9. Encourage the resident to perform every activity up to his maximal capabilities within the framework of his disabilities.
10. Support the resident by giving justifiable praise for effort put forth and for acts accomplished.

Revised 12/18

ASSISTING THE RESIDENT 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, and bed to wheelchair).

Weight-bearing transfers - carried out by residents who have at least one stable lower extremity (hemiplegics, unilateral lower extremity amputees, residents with hip fractures).

Non weight-bearing transfers - 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 Resident to the Edge of the Bed
 - a. Move the resident's head and shoulders toward the edge of the bed.
 - b. Move his feet and legs to the edge of bed. (The resident is now in a crescent position giving good range of motion to the lateral trunk muscles).
 - c. Place both of your arms well under the resident's hips. (Before the next maneuver, tighten or set the muscles of your back and abdomen.)
 - d. Straighten your back while moving the resident toward you.
 - e. Technique for Sitting the Resident on the Edge of the Bed
 - f. Place one hand under resident's shoulders.
 - g. Instruct the resident to push his elbow into the bed while you lift his 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 resident's trunk).
2. Technique for Assisting the Resident to Stand
 - a. Place the resident's feet well under him.
 - b. Face the resident and firmly grasp each side of his rib cage.
 - c. Push your knee against one of the resident's knees.
 - d. Rock the resident forward as he comes to a standing position. (Your knee is pushed against the resident's knee as he comes to the standing position.)
 - e. Ensure that the resident's knees are "locked" (full extension) while he is standing. (Locking the resident's knees is a safety measure for those residents who are weak or who have been in bed for a period of time.)
 - f. Give the resident enough time to balance himself.
 - g. Pivot the resident, positioning him to sit in the chair.
3. 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.)

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- b. When the muscles that the resident uses to lift himself off the bed are not strong enough to overcome the resistance of body weight, use the following maneuver:
 1. Place one side of the sliding board under the resident's buttocks and the other side on the surface of the chair, bed toilet, etc., to which the transfer is being made.
 2. Instruct the resident to push up with his hands, to shift his buttocks and to slide across the board to the other surface.

Revised 12/18

TECHNIQUE FOR WALKING WITH A CANE

Instruct resident 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.

Revised 12/18

MECHANICAL RESIDENT LIFT

The mechanical 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 for a Hoyer lift and one (1) for a sit to stand lift.

BED TO CHAIR

Procedure

1. Assemble and check equipment and explain procedure to resident.
2. Allow room for maneuvering.
3. Position resident as appropriate.
4. Refer to appropriate manufacturer's instructions for proper use of equipment.
5. Once resident is securely transferred, all attachments may be released.

11/02, Reviewed 03/15; Revised 07/08, 03/17, Reviewed 12/18

HYDROCOLLATOR PACKS

The purpose of Hydrocollator Packs is to decrease pain in a specific joint. 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 resident comfort, more padding should be used.
3. Hot packs should be placed only on the area designated by the Physical Therapist in the resident'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 resident 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.

Revised 12/18

RESTORATIVE PROGRAM

The restorative program at ISVH-B is monitored by a licensed nurse and supervised by the DNS/Administrator.

The restorative program promotes optimal function in each resident's physical, mental and psychosocial wellbeing.

Restorative care requires a trans disciplinary approach with collaboration between therapy and nursing services throughout the continuum of care.

Role Delineation:

1. Nursing
 - a. Supervise program
 - b. Manage program
 - c. LPN documentation quarterly and more frequently if needed. Monitoring of daily flow record documentation.
2. CNA/Restorative Aides
 - a. Carry out resident's restorative plan of care
 - b. Document on daily flow records.
 - c. Weekly summary
 - d. Monitor for changes in status or tolerance to program and report to LPN.
3. Therapy
 - a. Assist with identification of appropriate candidates for restorative program.
 - b. Suggest appropriate treatment interventions.
 - c. Set goals and interventions for restorative programs and progress.

Programs:

ROM- Active/Passive; group exercises Ambulation

Transfers

Support of ADL's

Feeding – Monitoring for positioning, equipment needs, cueing Bowel/Bladder retraining.

Revised 12/18

PROCESS FOR RESTORATIVE PROGRAM

1. Referral to Restorative Program
 - a. Admission of new resident
 - b. Referral from any team member that notices a change in status or potential need
 - c. Committee referral following incident/accident
2. MD order to proceed with program (may request PT/OT/ST/Restorative evaluation)
3. Written restorative program
 - a. Goals
 - b. Interventions
 - c. Frequency of care to be provided
4. Provision of care per treatment plan
5. Daily documentation on flow sheet
6. Weekly summary by Restorative Aide
7. Periodic and quarterly reviews by LPN
8. Participation in MDS/Care planning
9. Monitor/update/discontinue program as indicated by resident's needs.

Revised 12/18

RESIDENT SAFETY

Resident safety will be uppermost in the minds of all employees of the Idaho State Veterans Home Nursing Care Unit. Those not assigned to care giver duties will assist in monitoring the environment to keep it safe for all those who live and work on premises.

Safety Factors	Points of Emphasis
Wheels on beds, stretchers, wheelchairs, shower chair, resident lifts, commodes etc. should be locked when stationary.	<p>To keep the vehicle from moving during resident transfer.</p> <p>To keep the vehicle from rolling if struck accidentally.</p> <p>To keep resident from moving vehicle away from specific locations contrary to indication.</p>
Resident beds should be kept at the bed height designated for the individual resident, except during direct resident care. Restorative staff set individualized resident bed height by placing the rope & washer on headboard to indicate the proper height, when tip of rope touches the floor.	<p>To allow ambulatory resident to enter and leave bed without assistance.</p> <p>To reduce possibility of injury if resident attempts to leave bed when contraindicated.</p>
Call lights should be placed and attached in easy reach of resident at all times.	<p>Instruct resident on use of call light</p> <p>Call light cord should be clamped to bedding or gown within easy reach of resident.</p> <p>Call light cord should always be long enough for resident to reach when head of bed is elevated or when up in a chair.</p>
Bedside table should be placed where it may be easily reached by the resident.	<p>It should be placed on most useful side for the resident.</p> <p>Top should hold items such as water pitcher and glass, tissues, etc.</p> <p>It should not contain supplies, dirty equipment or anything potentially dangerous to resident.</p>
Over-bed table	Used for resident comfort, supportive
Safety Factors	Points of Emphasis
Stretchers should be equipped with sides and/or straps to provide safety for the resident being transported or awaiting treatment.	<p>Explain reason for safety precaution to resident</p> <p>Sides and/or straps should be used when provided.</p> <p>Resident should be comfortably positioned, with head elevated when possible and should be adequately covered.</p> <p>Be sure resident's arms are not extended beyond sides of stretcher.</p>

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	Acutely ill, restless or emotionally disturbed residents waiting for treatment should be attended.
Chairs, wheelchairs, Broda chair, recliner chair.	Call light cord should be placed within reach of resident in chair. Resident should not be placed on a bedpan on a chair. All residents to have a pressure reducing cushion in recliner unless otherwise documented by RN Manager or Skin/Wound Nurse.
Transfers	Gait belt MUST be used on transfers.

Revised 02/03, 03/15, 12/18

CODE LEADER CHECKLIST

TASK PERFORMED	TIME	YES	NO	N/A
Code overhead paged CODE BLUE				
911 Called				
Crash Cart present				
DNR checked				
Chart available				
Vital signs taken & recorded				
Blood sugar taken & recorded				
Area cleared of other residents & family				
Staff assigned to escort EMT				
Physician notified				
Family notified				
DNS notified				
ED notified				
Chart information copied for transport <ul style="list-style-type: none"> • Facesheet • MAR/TAR • Monthly orders • H & P • CODE documents • POA documents • Completed transfer sheet 				

Signature: _____ Date: _____

4/00, Revised 10/13, 05/15, 03/17

CPR PERFORMANCE SHEET

Resident Name: _____ Date: _____

Name of Staff who identified code:		
Time Code identified:		
Pulse Rate:	Resp Rate:	BP:
Time Code started:	<input type="checkbox"/> rescue breathing only <input type="checkbox"/> Chest compression & ventilations (both)	
Name of Staff participating in CPR: _____		
Compressions performed by: _____		
Ventilations performed by: _____		
Time 911 called:	Staff name who called:	
Time Crash Cart arrived:	Staff who brought cart:	
Resident moved to floor:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back board used:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List meds given:		
Blood Sugar obtained by:	Results:	
EMT arrived time:		
CPR taken over by EMT time:		
Time resident transported out of facility:		
If EMT's called code, give time:		
Comments:		

Signature of all staff who participated in CODE:

Recorder Signature:

DIALYSIS COMMUNICATION RECORD

Date: ____/____/____

DAY OF DIALYSIS (Pre-Dialysis)

VITAL SIGNS	BP	Pulse	Resp.	Temp.	Weight
Examine Access Site					
Location: _____ Condition: _____					
Time of Last Meal: _____					
Medications given within the last six (6) hours Pre-Dialysis: _____					
Note any changes to residents condition or special instructions: _____					
Nurse's Signature: _____			Time resident left for dialysis appt: _____		

DIALYSIS (To be completed by Dialysis Center following dialysis treatment and to accompany resident on return to ISVH)

VITAL SIGNS	BP	Pulse	Resp.	Temp.	Weight
PRE					
POST					
Access Condition: _____					
Medications given during/after dialysis treatment: _____					
Special Instructions/Comments and/or changes in resident condition. Include any lab results drawn and resident's tolerance to dialysis					
Provide a copy of the Registered Dietitian's nutritional recommendations, if applicable.					
INSTRUCTIONS: Both white and yellow copies accompany resident to dialysis center for completion. White copy to return to ISVH with resident upon return to facility and licensed nurse to review and follow up with ISVH physician as needed. Yellow copy may stay with dialysis center for their records.					
Dialysis Center Nurse Signature: _____			Date: _____		
Resident Name		Record #	Physician		

HYPOGLYCEMIA TREATMENT - REFERENCE GUIDE

<u>CATEGORY</u>	<u>SYMPTOMS</u>	<u>RESPONSE</u>
BLOOD GLUCOSE 70-80 mg/dl	NO SYMPTOMS	<ol style="list-style-type: none"> 1. GIVE 15 GRAMS OF CARBS, e.g. (4 OZ. OF ORANGE JUICE) PO 2. CHECK BLOOD GLUCOSE IN 15 MINUTES AND TREAT PER REFERENCE GUIDE 3. MAY HOLD ANY DIABETIES MEDICATIONS INCLUDING INSULIN IF BG < 80 mg/dl 4. NOTIFY PHYSICIAN – REVIEW GLUCOSES AND MEDICATIONS -NON-URGENT
MILD TO MODERATE HYPOGLYCEMI A BLOOD GLUCOSE 40-70 mg/dl	ALERT WITH SYMPTOMS ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. GIVE ONE OF THE FOLLOWING: <ol style="list-style-type: none"> a. 15 GRAMS OF CARBS, e.g. (4 OZ ORANGE JUICE) PO b. 1 TUBE ORAL GLUCOSE GEL 15 G. tube PO <ol style="list-style-type: none"> 1. GIVE LOW FAT MEAL OR SNACK 2. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 3. RECHECK BLOOD GLUCOSE AFTER 15 MINUTES 4. IF GLUCOSE < 40 TREAT AS MODERATE TO SEVERE HYPOGLYCEMIA BELOW. 5. IF GLUCOSE STILL 40-70 REPEAT TREATMENT PER STEP # 1 ABOVE AND RECHECK IN 15 MINUTES. 6. IF GLUCOSE > 70, GIVE LOW FAT MEAL OR SNACK, RECHECK BG IN 15 MINUTES, AND FOLLOW REFERENCE GUIDE 7. NOTIFY PHYSICIAN VIA SECURE MESSAGE- REVIEW GLUCOSES AND MEDICATIONS 8. <u>NOTIFY RN MANAGER and/or DNS</u> 9. <u>NOTIFY FAMILY/RESPONSIBLE PARTY</u>
MODERATE TO SEVERE HYPOGLYCEMI A BLOOD GLUCOSE <40 mg/dl	ALERT ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. GIVE ONE OF THE FOLLOWING: <ol style="list-style-type: none"> a) 1 TUBE ORAL GLUCOSE GEL 15 G. tube PO <ol style="list-style-type: none"> 1. GIVE LOW FAT MEAL OR SNACK 2. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 3. WAIT 15 MINUTES, RECHECK BLOOD GLUCOSE LEVEL 4. IF BLOOD GLUCOSE STILL <40 REPEAT STEP # 1 ABOVE AND RECHECK IN 15 MINUTES. 5. IF BLOOD GLUCOSE STILL < 40 GIVE GLUCAGEN 1 MG IM IN UPPER ARM OR THIGH AND RECHECK IN 15 MINUTES. 6. IF GLUCOSE STILL <40 OR RESIDENT BECOMES UNRESPONSIVE CALL 911 7. IF GLUCOSE > 40 but < 70 & ABLE TO SWALLOW, REPEAT STEP #1. ABOVE and GIVE LOW FAT MEAL OR SNACK AND RECHECK IN 15 MINUTES AND FOLLOW REFERENCE GUIDE 8. <u>NOTIFY PHYSICIAN BY PHONE CALL AS SOON AS POSSIBLE - REVIEW GLUCOSES AND MEDICATIONS</u> 9. <u>NOTIFY RN MANAGER and/or DNS</u> 10. <u>NOTIFY FAMILY/RESPONSIBLE PARTY</u>
<u>CATEGORY</u>	<u>SYMPTOMS</u>	<u>RESPONSE</u>
MODERATE TO SEVERE HYPOGLYCEMI A BLOOD GLUCOSE <40 mg/dl	UNRESPONSIVE, UNABLE TO SWALLOW SEIZURES ARE POSSIBLE	<ol style="list-style-type: none"> 1. CALL 911 2. NOTIFY PHYSICIAN and RN MANAGER and/or DNS 3. NOTIFY FAMILY/RESPONSIBLE PARTY 4. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 5. ASSESS AIRWAY, CHECK VITAL SIGNS, PROTECT FROM FALLS AND INJURIES FROM POSSIBLE SEIZURES 6. GIVE GLUCAGEN 1MG IM IN UPPER ARM OR THIGH 7. WAIT 15 MINUTES, RECHECK BLOOD GLUCOSE AND VITAL SIGNS 8. IF BLOOD GLUCOSE STILL <40 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 15G. PO AND GIVE LAW FAT MEAL OR SNACK 10. IF RESIDENT REMAINS UNRESPONSIVE CONTINUE TO MONITOR AIRWAY AND PULSE CLOSELY, BE PREPARED TO START CPR IF RESIDENT IS FULL CODE.

Implanted Pain Pump Order Sheet

1. Implanted Pump Information: Pump type and site: _____
2. Pump Insertion date: _____
3. Medication and Dose including concentration and diagnosis: _____
4. Type of Pump alarm: _____
5. Alarm Date: _____ Alarm setting: _____
6. All implanted pain pump dose adjustments, reservoir changes, refills, alarm settings, rate changes will be managed by the medical staff and/or designees at: _____
7. Contact information for clinic managing pump:

Phone number: _____ After-hours phone number: _____

8. Next Pain pump appointment: _____

9. After each pain pump appointment update pump information via MD orders include: concentration, rate, alarm date and alarm setting.
10. After, clinic appointment: Document time of return. Remove dressing 1 hour after return if present and monitor for bleeding, fluid leakage, increased abdominal pain distention. LN to doc 'Y' if no s/sx noted are present, doc 'N' if s/sx select 9 'other/see progress notes' and progress note findings and document s/sx & also notify MD and pump clinic.
11. Monitor implanted pump site QD for redness, irritation, drainage, swelling, pain. LN to doc 'Y' if no s/sx are present. Doc 'N' if s/sx present select chart code 9 'other/see progress notes' and progress note findings. Notify MD and pump clinic.
12. Monitor QD for s/sx of implanted pump complications: infection, fever, tachypnea, tachycardia, malaise, altered mental status, sudden severe back pain, loss of bowel and bladder control, s/sx of meningitis, sudden onset of leg weakness or spasm, kinking, coiling, or breaking of catheter, battery failure. Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
13. Monitor QD for s/sx of _____ under dose/withdrawal:

_____ Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.

14. Monitor QD for s/sx of _____ overdose:
_____ LN Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
15. Alarm monitor: Auscultate over pump site QD to assess for alarm sound. LN to Doc 'Y' no alarm sound is present. Doc 'N' if alarm sound is present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.

*Copy of these orders to be given to pharmacy

Nurse Signature: _____ Physician Signature: _____

Resident Name: _____ Physician: _____ Date: _____

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BLADDER SCANS

Facility staff will perform bladder scans per the following:

1. Prior to conducting a bladder scan staff will be trained on the use and competence will be verified through successful completion of the Bladder Scan Skills Checklist.
2. Bladder scans will be conducted on residents per the following:
 - a. Physician order.
 - b. Resident has a diagnosis that fits federal and state regulations for monitoring for possible urinary retention – refer to Bladder Assessment and Incontinence Management procedure.
 - 1). Instructions related to when bladder scans will be obtained will be directed by the licensed nursing staff.
 - 2). Results of the bladder scans will be documented either on the Bladder Data Collection sheet or the eTAR – per instructions.
 - c. Resident has a urinary tract infection and bladder scans are performed to help determine if urinary retention may be a causative factor.

8/07, 11/14

BLOOD GLUCOSE MONITORING SYSTEM – QUALITY ASSURANCE

Purpose

To validate the performance of the QUINTET Blood Glucose Monitoring System 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:

- Each night to verify meter accuracy.
- 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.

To perform a Quality Control Test, prepare the items below:

- QUINTET AC meter
- QUINTET AC Test Strips
- Normal or High-Level CONSULT Control Solution

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 is valid. Test strips are to be used within three (3) months of opening.
2. Insert test strip with view window, facing up, into the test strip port.
3. While the "**drop**" symbol is flashing, press and hold the main button for over 3 seconds until the "**cs**" symbol appears.

4. When you see the "**drop**" and "**cs**" symbols blinking on the screen, promptly apply the CONSULT Control Solution.
5. Shake the vial of Control Solution well before opening the cap. Open the cap and set on a flat surface with the tip pointing up.
6. Drip one drop of the Control Solution on the top of the cap.
7. Gently touch the sample entry of the test strip with the Control Solution on the top of the cap.
8. When a "beep" is heard, wait for the test result. The screen will show a countdown mode from 5.
9. Tightly recap the Control Solution.
10. 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.
11. If the Control Solution test results are out of the Control Solution range, the QUINTET AC System may not be working properly.
 - 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.
 - Repeat the Quality Control Test. If the control solution tests outside the range again, do not use the QUINTET system to test blood glucose. Call Central Supply and ask for a replacement.

7/00 – Revised 12/03, 11/09, 10/15

PERFORMING A BLOOD GLUCOSE TEST

Procedure:

1. Carry Quintet AC 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 resident's privacy.
4. Perform hand hygiene 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 3 months from the day they are opened.
7. Remove a new test strip from the vial and re-cap the vial immediately.
8. Insert the test strip into test strip port with the indication symbol facing up. The meter confirms the insertion of the strip with a beep.
9. The "drop" symbol will appear and will be accompanied by a "beep" that will sound. The meter is now ready for testing.
10. Prepare resident's fingertip with an alcohol pad and allow to air dry.
11. Place the end of the lancet against the fingertip and release the trigger to obtain a blood sample.
12. Touch and hold the blood drop on the sample entry until you hear a "beep" and the view window is totally filled with blood.
13. You will see the countdown mode on the screen. After 5 seconds, the test result appears. The result with the time and date is automatically stored in the meters memory.
14. Rotate the test strip counterclockwise and pull up at the same time to completely remove the test strip out of the test strip port and discard the used test strip properly.
15. Disinfect blood glucose machine using a Super Sani-cloth disposable wipe. Thoroughly wet surface with wipe. Allow treated surface to remain wet for a full 2 minutes. Let air dry.
16. Remove gloves and perform hand hygiene.
17. Discard the used lancet in the sharp's container.
18. Chart blood glucose results in eMAR.

12/11, 11/14, 07/15, 10/15, 08/17

BOWEL PROGRAM / PRN BOWEL MEDICATIONS

Purpose

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

Procedure

1. A resident's bowel pattern will be documented in Point of Care (POC) every shift.
2. The NOC shift nurse will initiate the bowel work sheet, begin interventions as appropriate, and then submit worksheet to the day shift licensed nurse.
3. The licensed nurse will write/implement standing orders (if no PRN order already in place) for progressive bowel elimination intervention.
4. Completed bowel work sheet shall be submitted to unit RN Manager at end of PM shift with bowel elimination results documented on worksheet.
5. MD will be notified of residents who require frequent use of standing order bowel medications for consideration of adding scheduled medications as appropriate and consideration for inclusion in the Fruit-Eze Program.

PRN BOWEL MEDICATIONS

1. When administering a PRN bowel medication, indicate in the eMAR progress note reason for administration.
2. All PRN medications administered require follow up documentation as to results. Document in the eMAR.

Revised 12/11, 03/13, 05/14, 11/14

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-B.

Procedure

1. Prior to resident leaving for each dialysis appointment
 - a. Complete the top portion of the Dialysis Communication Record (see attached) 1). Obtaining vital signs, B/P, temperature, pulse and respirations.
 - 1). Obtain residents weight.
 - 2). Examine vascular access site note location and condition (i.e. erythema, excessive tenderness, swelling, drainage) and note any issues on the Dialysis Communication Record.
 - 3). Note any medications given prior to dialysis 5). Note time of resident's last meal.
2. Assess the resident on return from the dialysis unit.
 - a. Check for bruit and thrill at the vascular access site.
 - b. Check for bleeding.
 - c. Check for S/S of infection at vascular site (i.e. erythema, excessive tenderness, swelling, drainage).
 - d. Check condition of resident.
 - e. Make resident comfortable.
 - f. Do not allow the resident to wear constricting clothes over the graft arm or leg.
 - g. Do not allow anyone to take a blood pressure or blood sample on the graft arm or leg.
 - h. Do not allow the resident to carry anything heavier than 10 pounds with the arm.
3. If there is a change in the bruit and thrill or any excess bleeding and/or changes of the vascular access site, notify the physician immediately.
4. Remove the pressure dressing from vascular access site on the fourth hour, note time, and watch for bleeding.
5. Primary nurse to review returned Dialysis Communication Report and follow up with any physician orders or special problems encountered during dialysis.
6. Document in the nursing notes a summary of the resident's condition.
7. Check q shift the bruit and thrill.

02/03; Updated 9/10

DIALYSIS COMMUNICATION RECORD

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DIALYSIS COMMUNICATION RECORD					
Date: ___/___/___					
DAY OF DIALYSIS (Pre-Dialysis)					
VITAL SIGNS	BP	Pulse	Resp.	Temp.	Weight
Examine Access Site					
Location: _____ Condition: _____					
Time of Last Meal: _____					
Medications given within the last six (6) hours Pre-Dialysis: _____					
Note any changes to residents condition or special instructions: _____					
Nurse's Signature: _____			Time resident left for dialysis appt: _____		
DIALYSIS (To be completed by Dialysis Center following dialysis treatment and to accompany resident on return to ISVH)					
VITAL SIGNS	BP	Pulse	Resp.	Temp.	Weight
PRE					
POST					
Access Condition: _____					
Medications given during/after dialysis treatment: _____					
Special Instructions/Comments and/or changes in resident condition. Include any lab results drawn and resident's tolerance to dialysis					
Provide a copy of the Registered Dietitian's nutritional recommendations, if applicable.					
INSTRUCTIONS: Both white and yellow copies accompany resident to dialysis center for completion. White copy to return to ISVH with resident upon return to facility and licensed nurse to review and follow up with ISVH physician as needed. Yellow copy may stay with dialysis center for their records.					
Dialysis Center Nurse Signature: _____			Date: _____		
Resident Name	Record #	Physician			

DRESSING CHANGES

Protocol for dressing changes will be as follows:

Sterile technique will be followed post-operatively for all surgical interventions or debridement's 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. Perform hand hygiene.
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 the 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. Perform hand hygiene 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. Nurse shall put initials, date and time on the clean dressing.
15. Clean work area, discarding all contaminated materials in the appropriate receptacle or double bag if required.
16. Leave unused dressings or supplies at bedside, or discard if contaminated.
17. Ensure no sharp objects are left in trash or linens that could puncture bags or cause staff injury.
18. Perform hand hygiene.

Revised 11/03, 04/06, 08/17

EAR IRRIGATIONS

Ear irrigations may be performed by licensed staff as ordered by the resident's medical provider. All residents with hearing aids should be checked routinely for cerumen and ears should be irrigated as per physician order.

Debrox or like softening agent, should be used prior to irrigations.

Warm water, a bulb syringe, emesis basins and towels should be gathered prior to beginning the procedure.

Irrigate until returns are clear, and the otoscope reveals that all impacted wax is removed. If ordered, a water-pik may be used, in certain circumstances, to irrigate ears.

INSTILLATION OF EYE DROPS

Perform hand hygiene and apply gloves.

Instill drops as directed, dropping medication onto conjunctiva sac of lower lid.

Allow for optimal eye drop absorption – approximately 5 minutes before instilling next eye drop.

Record medication and time given.

Remove gloves, perform hand hygiene before proceeding to next resident.

APPLICATION OF EYE OINTMENT

Perform hand hygiene and apply gloves.

Wipe off tip of ointment tube after expressing and discarding small amount of medication. Instill ointment onto conjunctiva sac of lower lid.

Instruct resident to close eye and allow ointment to melt. Record medication and time given.

Remove gloves, perform hand hygiene before proceeding to next resident.

Revised 02/00, 08/17

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 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 licensed nurse is responsible for documenting the intake on the resident's eMAR/eTAR as appropriate.

03/00: Revised 11/00, 02/02, 02/03, 11/14

HYPOGLYCEMIA

Purpose: To define the standard protocol for treatment of hypoglycemia

Definitions:

Hypoglycemia – occurs when the blood sugar is at or 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.

Mild to Moderate Hypoglycemia – Blood sugars are between 40-70 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.

Severe Hypoglycemia – Blood sugar is less than 40 mg/dl. Blood sugars less than 40 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 (Give no more than 30 minutes before meal)	About 30 minutes	2 – 4 hours	5 – 8 hours
Insulin – NPH (Given 1 hour before breakfast and at bedtime)	About 2 hours	6 – 10 hours	18 – 28 hours
Combination 70/30 (Give 30 minutes before meal; do not give after 5:30 pm; combined with regular)	About 30 minutes	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

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.
 - a. Monitor shall read: Monitor resident for s/s 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 glucose FSBG levels shall be obtained by a licensed nurse, as ordered, and PRN based on assessment and FSBG levels. For FSBG <80 mg/dl, refer to Hypoglycemia Treatment Reference Guide (located in the red reference binder located on each med cart).
2. For FSBG levels <80 but not less than 70 mg/dl
 - a. Document intervention(s) in the eMAR, including the repeat FSBG results.
 - b. FSBS levels and diabetic medication will be reviewed with physician.
3. For FSBS levels <70 mg/dl
 - a. Document interventions in the nurses' note section of the medical record.
 - b. If interventions included administering Glucose Gel or GlucaGen then the licensed nurse shall write the applicable physician's standing order.
 - c. Documentation for resident's experiencing hypoglycemia, shall include a nursing assessment of any signs/symptoms the resident is demonstrating/experiencing and their resolution.
 - d. FSBS levels and diabetic medications will be reviewed with the physician.
4. 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 "N" on eMAR order and select 9 'other/see progress notes' and progress note findings and document reason FSBS not obtained.

Holding diabetic medication:

1. Licensed nurse may hold insulin if the blood glucose level is <80 mg/dl (and intervene per the Hypoglycemia Treatment Reference Guide).

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2. Licensed nurse may hold AC (before meals) insulin if the resident is not expected to eat within 60 minutes of the insulin administration.
3. Licensed nurse shall document the rationale for decision in eMAR by selecting 'N' and then select 9 'other/see progress notes' and progress note findings.

7/08; Revised 6/09, 11/14, 05/15

HYPOGLYCEMIA TREATMENT - REFERENCE GUIDE

<u>CATEGORY</u>	<u>SYMPTOMS</u>	<u>RESPONSE</u>
BLOOD GLUCOSE 70-80 mg/dl	NO SYMPTOMS	<ol style="list-style-type: none"> 1. GIVE 15 GRAMS OF CARBS, e.g. (4 OZ. OF ORANGE JUICE) PO 2. CHECK BLOOD GLUCOSE IN 15 MINUTES AND TREAT PER REFERENCE GUIDE 3. MAY HOLD ANY DIABETIES MEDICATIONS INCLUDING INSULIN IF BG < 80 mg/dl 4. NOTIFY PHYSICIAN – REVIEW GLUCOSES AND MEDICATIONS
MILD TO MODERATE HYPOGLYCEMIA BLOOD GLUCOSE 40-70 mg/dl	ALERT WITH SYMPTOMS ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. GIVE ONE OF THE FOLLOWING: <ol style="list-style-type: none"> a. 15 GRAMS OF CARBS, e.g. (4 OZ ORANGE JUICE) PO b. 1 TUBE ORAL GLUCOSE GEL 15 G. tube PO 1. GIVE LOW FAT MEAL OR SNACK 2. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 3. RECHECK BLOOD GLUCOSE AFTER 15 MINUTES 4. IF GLUCOSE < 40 TREAT AS MODERATE TO SEVERE HYPOGLYCEMIA BELOW. 5. IF GLUCOSE STILL 40-70 REPEAT TREATMENT PER STEP # 1 ABOVE AND RECHECK IN 15 MINUTES. 6. IF GLUCOSE > 70, GIVE LOW FAT MEAL OR SNACK, RECHECK BG IN 15 MINUTES, AND FOLLOW REFERENCE GUIDE 7. <u>NOTIFY PHYSICIAN - REVIEW GLUCOSES AND MEDICATIONS</u> 8. <u>NOTIFY RN MANAGER and/or DNS</u> 9. <u>NOTIFY FAMILY/RESPONSIBLE PARTY</u>
MODERATE TO SEVERE HYPOGLYCEMIA BLOOD GLUCOSE <40 mg/dl	ALERT ABLE TO SWALLOW	<ol style="list-style-type: none"> 1. GIVE ONE OF THE FOLLOWING: <ol style="list-style-type: none"> a) 1 TUBE ORAL GLUCOSE GEL 15 G. tube PO 1. GIVE LOW FAT MEAL OR SNACK 2. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 3. WAIT 15 MINUTES, RECHECK BLOOD GLUCOSE LEVEL 4. IF BLOOD GLUCOSE STILL <40 REPEAT STEP # 1 ABOVE AND RECHECK IN 15 MINUTES. 5. IF BLOOD GLUCOSE STILL < 40 GIVE GLUCAGEN 1 MG IM IN UPPER ARM OR THIGH AND RECHECK IN 15 MINUTES. 6. IF GLUCOSE STILL <40 OR RESIDENT BECOMES UNRESPONSIVE CALL 911 7. IF GLUCOSE > 40 but < 70 & ABLE TO SWALLOW, REPEAT STEP #1. ABOVE and GIVE LOW FAT MEAL OR SNACK AND RECHECK IN 15 MINUTES AND FOLLOW REFERENCE GUIDE 8. <u>NOTIFY PHYSICIAN AS SOON AS POSSIBLE - REVIEW GLUCOSES AND MEDICATIONS</u> 9. <u>NOTIFY RN MANAGER and/or DNS</u> 10. <u>NOTIFY FAMILY/RESPONSIBLE PARTY</u>
<u>CATEGORY</u>	<u>SYMPTOMS</u>	<u>RESPONSE</u>
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 and RN MANAGER and/or DNS 3. NOTIFY FAMILY/RESPONSIBLE PARTY 4. HOLD ANY DIABETES MEDICATIONS INCLUDING INSULIN 5. ASSESS AIRWAY, CHECK VITAL SIGNS, PROTECT FROM FALLS AND INJURIES FROM POSSIBLE SEIZURES 6. GIVE GLUCAGEN 1MG IM IN UPPER ARM OR THIGH 7. WAIT 15 MINUTES, RECHECK BLOOD GLUCOSE AND VITAL SIGNS 8. IF BLOOD GLUCOSE STILL <40 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 15G. PO AND GIVE LOW FAT MEAL OR SNACK 10. IF RESIDENT REMAINS UNRESPONSIVE CONTINUE TO MONITOR AIRWAY AND PULSE CLOSELY, BE PREPARED TO START CPR IF RESIDENT IS FULL CODE.

INJECTIONS

Subcutaneous Injections

Medications administered via subcutaneous injection must be ordered via that route/type of injection.

1. Medications typically ordered via subcutaneous injection are insulin and heparin.
2. Subcutaneous injections are typically administered through a 27-gauge needle - tuberculin-type syringe.
3. To administer a subcutaneous injection:
 - a. Clean site with alcohol and allow to dry
 - b. Gently raise a fold of skin
 - c. Inject needle at a 45-90-degree angle.
 - d. Inject medication slowly.
 - e. Place alcohol sponge over injection site and quickly withdraw needle.
 - f. Do NOT rub injection site.
 - g. Discard needle and syringe in appropriate receptacle.
 - h. Record in electronic medication administration record (eMAR), including site of injection.

Intra-Muscular Injections

Medications administered via intra-muscular injection must be ordered via that route/type of injection.

1. Medications typically ordered via intra-muscular injection are antibiotics and vaccines.
2. Intra-muscular injections are typically administered through a 1.5-3-inch 19-23 gauge-needle.
3. Sites used are deltoid, ventrogluteal, dorsogluteal, and lateralis muscles.
4. No more than 2 cc. Is typically administered into one site.
5. To administer an intra-muscular injection:
 - a. Position resident, select site, and clean site with alcohol sponge.
 - b. Insert needle quickly at a 90-degree angle.
 - c. Aspirate to see if needle is in a blood vessel. If so, use a new needle and syringe and draw up medication again.
 - d. Withdraw needle quickly while applying pressure and massage site with alcohol prep.
 - e. Discard needle and syringe in appropriate receptacle.
 - f. Record in electronic medication administration record (eMAR), including site of injection.
 - g. Observe resident for adverse reactions. If side effects are present, notify the nurse manager and physician.
 - h. Document in nurse progress notes and complete an adverse drug reaction form.
 - i. Update care plan and resident allergies as needed.

01/03, 11/14

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 *BVH 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. Licensed nursing staff is responsible for turning ON the nebulizer unit and OFF, at the conclusion of treatment.
5. 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.
6. If the resident is unable to hold the nebulizer unit then a face mask-type nebulizer unit shall be considered.
7. The nebulizer unit shall be rinsed out with warm water following each use, placed on a paper towel to air dry, and placed in the draw string plastic bag located by the nebulizer unit.
8. Replacement of the nebulizer unit/tubing shall occur per Equipment/Supplies Cleaning/Disposal Schedule.

11/00, 11/14, 05/19

NOC DUTIES – LICENSED NURSE

The NOC nurse on each unit shall be responsible for the following tasks.

1. Provide assignments to aides.
2. Obtain report from previous shift nurse.
3. Round on all residents.
4. Administer medications and treatments as ordered.
5. Record medication and lab refrigerator temps Q shift.
6. Test eye wash station(s) weekly (Sunday). Record results.
7. Test glucometer(s) nightly, record results (refer to Blood Glucose Monitoring System).
8. Initiate 24-hour shift report.
9. Initiate Bowel Worksheet.
10. Check calendar and communicate necessary information for day shift.
11. Clean and stock med carts.
12. Conduct 24-hour chart check nightly.
13. Change out/over equipment and supplies per Nursing Procedural Manual – Equipment /Supplies Cleaning/Disposal Schedule – Section VIII.
14. Check bubble packs and reorder medications as needed (plan for weekends and holidays).
15. Check med room and med carts for outdated medications 1x month – 20th day - place in med room for pharmacy pick-up.
16. Complete census sheet.
17. Complete assigned Focus and Alert Charting.
18. Complete monthly summaries (per schedule).
19. Address staff call-ins – including filling shifts – follow established procedure.
20. Check and sign that the Emergency Response cart is locked and emergency equipment (O², suction, ambu bag) are functional.

08/07, revised 08/09, 1/11, 11/14, 08/18

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 is administered by licensed staff and/or by the resident under supervision of the licensed nurse.
 - 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.)
2. Oxygen tanks are kept on each nursing unit in the oxygen closet.
3. If supplies are not available, storekeeper may be contacted.
4. Portable liquid oxygen reservoirs are typically used when the resident is ambulatory or uses a wheelchair.
 - a. E tanks (small green) may be utilized when necessary.
5. Concentrators (for below 5 liters) should be utilized when in room.
6. For residents with oxygen needs greater than 5 liters per minute, specialized portable oxygen and oxygen concentrators are obtained from Norco ((208) 898-0202). During normal business hours the Storekeeper may be contacted to obtain specialty equipment.
 - a. Humidification is recommended for liter flows greater than 4 liters and for all residents with trachs.
7. Place oxygen sign on doorjamb entering room.
8. Cannulas are the preferred equipment unless the resident/patient is a mouth breather.
9. Explain the procedure and safety precautions to the resident/patient and all caregivers.
10. Perform hand hygiene before and after procedure.
11. Obtain pre-filled humidification bottle.
 - a. Attach the wing nut in the humidifier to the oxygen source.
 - b. Connect supply tubing (cannula or mask) to the small nipple on the humidifier bottle. Be sure that all connections are secure.
 - c. Turn on the oxygen source to the prescribed liter flow.
 - d. Time and date bottle.
 - e. Change monthly/PRN per Equipment/Supplies Cleaning/Disposal Schedule.
12. Place mask on the face or cannula in nose and adjust for comfort. Foam covers for tubing around ears as needed.
13. Change masks and cannula as needed and in accordance with the facility's equipment changeover schedule.
14. Update resident's care plan as needed.

Revised 4/11, 06/17, 08/17, 05/19

CPAP/BIPAP/VPAP – RESPIRATORY CARE

1. CPAP/BIPAP/VPAP is administered appropriately to improve oxygenation in spontaneously breathing residents with or without supplemental oxygen and promote resident comfort and safety.
 - a. CPAP/BIPAP/VPAP is administered by licensed staff and/or by the resident under supervision of the licensed nurse.
 - b. CPAP/BIPAP/VPAP administration requires a physician's order.
 - c. Humidification is recommended with CPAP/BIPAP/VPAP use.
 - d. Each resident will be supplied with their own CPAP/BIPAP/VPAP system, tubing and mask. If resident requires a CPAP/BIPAP/VPAP machine adjustment or replacement and/or initial machine and equipment set up contact Central Supply who will call Norco (208) 898-0202, if after hours call Norco.
2. Perform hand hygiene before and after procedure.
3. Set up CPAP/BIPAP/VPAP machine:
 - a. Check humidification chamber and ensure that the chamber is filled with distilled water to the max fill line. Do not overfill chamber. Place the chamber back into the machine.
 - b. Connect one end of the humidifier hose to the CPAP/BIPAP/VPAP air outlet and the other end to the CPAP/BIPAP/VPAP mask.
 - c. Place the mask on the resident's face, turn the CPAP/BIPAP/VPAP system on and allow him/her to become acclimated to the pressure.
 - d. Once the resident is acclimated, secure mask on his/her face. The mask should fit firmly but does not need to be airtight.
 - e. Connect supplemental oxygen and adjust oxygen flow rate as prescribed.
4. Update resident's care plan as needed.
5. If the resident declines to wear the CPAP/BIPAP/VPAP notify physician.
6. Clean mask and tubing as needed and in accordance with the facility's Equipment/Supplies Cleaning/Disposal schedule.
7. CPAP/BIPAP/VPAP filters- Reusable and Disposable filters will be changed every 3 months by the Central Supply Department. Central Supply will wash reusable filters by hand in warm soapy water and allowed to air dry before reuse.
8. Central supply will routinely replace CPAP/BIPAP/VPAP system head gear, mask frame and mask cushion every 3 months and chin strap, humidifier, chamber and tubing every 6 months.
9. If the resident is experiencing problems with the equipment or the case of an emergency contact Norco (208) 898-0202.

01/11, Revised 05/15, 01/17, 08/17

RESUSCITATION

- 1) 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 within 24 hours.
- 3) In the event that code status is not yet delineated the resident is to be considered a FULL CODE status.
- 4) 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).
- 5) In the event a resident has FULL CODE status and an arrest has been witnessed/diagnosed:
 - a) Overhead page "CODE BLUE" and location of Code.
 - b) Access 911
 - c) Bring Code Cart to site, initiate CPR and Code Leader Checklist.
 - d) Nurse continues CPR until there is:
 - i) Restoration of effective, spontaneous circulation and ventilation;
 - ii) Care is transferred to a more senior level of emergency medical professional who may determine unresponsiveness to resuscitation;
 - iii) Or the rescuer is unable to continue resuscitation due to exhaustion and there is no one else to take over resuscitation efforts.
 - e) Facility staff to contact resident's physician and relay resident's current condition and obtain further instructions.
 - f) Complete Code Leader Checklist and CPR Performance Sheet and put in Nurse Managers box.
- 6) EXCEPTIONS to instituting CPR when the resident has FULL CODE status and an arrest has been diagnosed are as follows:
 - g) Resident is found to have Dependent Lividity – a pooling of blood in the body after the heart has stopped beating and the blood becomes subject to gravity and begins to settle in the lower portions of the body (dependent regions), and looks similar to bruising.
 - h) Resident is found to have Rigor Mortis – the stiffening of muscles due to absence of ATP after death.
 - i) Removal of a vital bodily organ including blood.
- 7) In the event the resident has DNI/DNR (do not intubate/do not resuscitate) code status, no CPR will be administered following an arrest diagnosis.
- 8) In the event of a resident's death the Postmortem Procedure shall be followed.
- 9) All resident assessment and resuscitation/intervention information will be entered in the resident's medical record in the progress note section.

4/00, Revised 10/13, 05/15, 03/17, 12/17, 08/18

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CPR PERFORMANCE SHEET

Resident Name: _____

Date: _____

Name of Staff who identified code:	
Time Code identified:	
Pulse Rate:	Resp Rate:
	BP:
Time Code started:	<input type="checkbox"/> rescue breathing only
<input type="checkbox"/> Chest compression & ventilations (both)	
Name of Staff participating in CPR: _____	
Compressions performed by: _____	
Ventilations performed by: _____	
Time 911 called:	Staff name who called:
Time Crash Cart arrived:	Staff who brought cart:
Resident moved to floor:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back board used:	<input type="checkbox"/> Yes <input type="checkbox"/> No
List meds given:	
Blood Sugar obtained by:	Results:
EMT arrived time:	
CPR taken over by EMT time:	
Time resident transported out of facility:	
If EMT's called code, give time:	
Comments:	

Signature of all staff who participated in CODE:

Recorder Signature:

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CODE LEADER CHECKLIST

TASK PERFORMED	TIME	YES	NO	N/A
Code overhead paged CODE BLUE				
911 Called				
Crash Cart present				
DNR checked				
Chart available				
Vital signs taken & recorded				
Blood sugar taken & recorded				
Area cleared of other residents & family				
Staff assigned to escort EMT				
Physician notified				
Family notified				
DNS notified				
ED notified				
Chart information copied for transport <ul style="list-style-type: none"> • Facesheet • MAR/TAR • Monthly orders • H & P • CODE documents • POA documents • Completed transfer sheet 				

Signature: _____ Date: _____

4/00, Revised 10/13, 05/15, 03/17

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

1. Explain procedure to resident and provide privacy.
2. Place resident in semi-Fowler's position.
3. If a fenestrated tracheostomy tube is in place, insert a plain inner cannula prior to suctioning.
4. 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).
5. Turn on suction pressure gauge, checking that the pressure is between 100-200mm HG.
6. Open suction catheter pack and attach suction port end to the suction tubing, leaving remainder of catheter in protective sleeve.
7. Put on disposable gloves and protective eyewear.
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 protective eyewear, perform hand hygiene.
21. Chart procedure, amount and nature of secretions, patient's tolerance of procedure.
22. Inform Unit Manager of any adverse reactions.
23. Discard suction canister per Equipment/Supplies Cleaning/Disposal Schedule.

11/03, 8/17, 08/18, 05/19

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, suction equipment (if appropriate), scissors, extra pair of sterile gloves and clean table drape.
2. Perform hand hygiene before and after treatment and wear gloves.
3. Place table drape (plastic side down) on work station (as your clean field).
4. Open tracheostomy tray (maintaining sterility), remove and don sterile gloves. Then remove 4 x 4's, trach ties and scrub brush and drop them onto the clean drape. Open the hydrogen peroxide and pour into one side of tray and then open the normal saline and pour ½ into the other section of the tray. Then place the remaining normal saline (in its container) on the clean drape. Then put the 4 x 4's into the normal saline that is on the clean drape.

Resident Preparation/Procedure:

1. Explain the procedure to resident and provide privacy.
2. Place resident in semi-Fowler's position.
3. Discard soiled dressings. Do not remove trach tapes at this point.
4. Use saline soaked 4 x 4's (Q-tips if needed) to clean around neck and trach site.
5. Remove inner cannula and place in hydrogen peroxide and let soak. If necessary, the nurse may wash/scrub the inner cannula at the sink under hot running water and then drop it in the hydrogen peroxide and let soak. Ensuring at all times that the sterile and clean fields are maintained.
6. If necessary, suction the entire length of outer cannula.
7. Remove now-contaminated sterile gloves and don new ones.
8. Remove inner cannula from the hydrogen peroxide, rinse in the basin of normal saline, and shake off excess saline.
9. Replace inner cannula and lock in place.
10. Using precut tracheostomy dressing, place around tracheostomy.
11. If tracheostomy tapes are soiled, replace them. Cut a slit approximately 1-1/2 inch from end of new tapes. Place tapes through tracheostomy openings and tie before removing soiled tapes.
12. Document procedure was done. If appropriate, document in the medical record the amount and character of drainage, condition of stoma and skin, and other pertinent observations.
13. Inform Unit Manager of any adverse reactions.

08/03, revised 02/06, 08/17, 05/19

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 e.g. 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 per MD order – feeding should be held if residual is > 100 cc. – document residual and if tube feeding is held
 - 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 30 cc of warm water.
6. Staff is responsible for monitoring resident for feeding complications such as diarrhea, gastric distention, aspiration and administering corrective actions.
7. Resident's head shall be elevated at least 30 degrees during and at least 30 minutes following each feeding. If the resident is on continuous feeding then personal cares, bed changes, etc., need to be made with the resident remaining elevated in order to prevent aspiration.
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 stored in a plastic bag (may be stored in the resident's room), and discarded every 24 hours.
 - b. Tubing and formula container shall be discarded every 24 hours.
 - c. If cans (not closed system) are used then wipe down lid prior to opening with alcohol wipe.

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- d. Any unused canned formula shall be stored in/on the med cart (dated/covered) and used within 48 hours of opening.
- 9. Feeding pump shall be wiped down q shift and checked q shift to ensure alarms are working and pump is fully operational
- 10. Staff shall use universal precautions when preparing and instilling the enteral feeding.

8/00, Revised 10/03, 06/08, 11/08, 03/09, 01/14, 03/14

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TUBE FEEDING SKILLS CHECK LIST

Employee Name _____

SKILL	YES	NO	COMMENTS
Does the order state (1) type of feeding (2) amount to be administered with each feeding (3) times of each feeding (4) rate of flow (5) type of flow (gravity/pump) (6) diagnosis requiring tube feeding (7) amount of free water with each med/feeding/flush (8) calories from each feeding			
Is resident properly positioned to receive enteral nutrition? (e.g. head elevated 30+ degrees)			
Is the amount to be fed the resident consistent with the order?			
Is the tubing dated? Is the irrigation syringe dated?			
Are the equipment/feeding cans/bags stored appropriately? (Only clean surface in a room is a paper towel)			
If cans are used, did the nurse wipe down prior to opening?			
Did the nurse obtain residuals prior to beginning tube feeding?			
Did the nurse check for proper tube placement prior to beginning the tube feeding?			
Did the nurse flush before and after the medications/feedings? (with at least 30 cc warm water)			
Did the nurse assess/document tube insertion site?			
Did the nurse monitor for feeding complications such as diarrhea, gastric distention, aspiration?			
Is the flow rate consistent with the order/consistent with proper tube feeding technique?			
Does the documentation include the amount of free water used in the flush?			

Signature of Nurse Evaluator

Date

URINARY/SUPRAPUBIC UROSTOMY & STRAIGHT CATHETER INSERTION

1. Catheters (urinary and suprapubic) are ordered by the individual resident's primary physician. Orders include catheter size, balloon size, schedule for replacement, 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 tubing and sterile equipment.
5. Catheters are inserted and maintained in a closed system.
6. The system may be opened under strict aseptic technique if the physician orders an irrigation or if the drainage bag requires changing.

Insertion

1. Obtain proper size catheter, along with syringe and sterile water for balloon inflation and sterile gloves.
2. Explain the procedure to resident and provide privacy.
3. Perform hand hygiene before and after procedure.
4. If catheter is to be removed, deflate balloon with a syringe and gently withdraw catheter.
5. Cleanse abdominal wall (suprapubic) or groin area (urinary) with Betadine.
6. Set up a sterile field
7. 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. Gently insert catheter 6-8 inches into urethra until urine flows. Do not force catheter.
8. For female catheterization:
 - a. Place resident in a lithotomy position with knees apart, provide sufficient light.
 - b. Separate labia with thumb and forefinger to expose meatus. Clean vulva and gently insert a catheter into urethra until urine appears
9. Insert catheter in opening, advance until urine passes through catheter opening and advance 2-3 inches, then inflate balloon with water
10. Attach to bedside drainage or leg bag. 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.
11. If drainage is poor, ensure catheter is not kinked.
12. Empty drainage bag PRN and q shift.
13. Document in the nurse progress notes or eTAR the reason for replacement or removal with date, time, and size, type of catheter used and size of balloon.

Straight Catheterization

1. Obtain straight catheterization kit (regular or coude').
2. Explain procedure to resident and provide privacy.
3. Position resident in appropriate position to allow for easier access to urethra.
4. Perform hand hygiene before and after procedure.
5. Apply sterile gloves.
6. Cleanse area surrounding point of catheter insertion.
7. Insert lubed catheter into urethra until urine flows into self-contained bag.
8. To completely empty bladder, slight pressure may be placed on lower abdominal area as appropriate. When bladder is empty, slowly withdraw catheter while pushing catheter into plastic drain bag.
9. Empty urine into toilet.
10. Dispose of urine drain bag in trash.

1/03, revised 04/06, 11/14, 08/17

IMPLANTED PAIN PUMP

Purpose

The use of permanently implanted pain pumps is becoming more common for residents with chronic uncontrollable pain. These pumps use an intrathecal catheter that is placed at the pain clinic. These pumps require intermittent refills that are done at the clinic as scheduled by appointment. In the event that the resident's condition has declined to a point he/she cannot tolerate transport to the clinic, other methods of pain control should be considered such as I.V., dermal, oral or I.M. medications. However, because the pump is surgically implanted, the facility will continue to monitor the pump site and the resident for complications related to it.

Procedure

1. When a resident is admitted with an implanted pain pump or an implanted pain pump is placed the RN Manager or their designee will:
 - A. Obtain physicians orders to identify:
 - a. Use of the implanted pain pump including pump type, insertion date and location.
 - b. Medication and dose to be delivered via pump including the concentration.
 - c. Type of alarm system the pump has and meaning of the alarms and what to do should the alarm start sounding.
 - d. Alarm Date and Alarm setting
 - e. Name of clinic that will manage the pain pump and contact information, including after-hours contact information
 - f. Next pain pump appointment
 - g. After each clinic appointment, LN to remove dressing 1 hour after appointment and monitor site for any bleeding, fluid leakage, increased abdominal pain or abdominal distention.
 - h. Monitor pump site daily for redness, irritation, drainage, swelling, pain.
 - i. Monitor daily for s/sx of complications r/t pain pump: Infection; fever, tachypnea, tachycardia, malaise, altered mental status, sudden onset of severe back pain, loss of bowel and bladder control, s/sx of meningitis, sudden onset of leg weakness or spasm, kinking/coiling/breaking of catheter, battery failure
 - j. Monitor daily for s/sx of side effects of the pump medication: under dose/withdrawal or overdose.
 - k. Monitor alarm daily by auscultating over pump site
 - B. Licensed nurse may use Implanted Pain Pump Order sheet to obtain above orders or write individual physicians orders.
 - C. Licensed nurse after each pump clinic appointment will update pump information via MD orders to include: concentration, rate, alarm date, and alarm setting.

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Nursing Procedure Manual

- D. The pharmacy will be notified of all pain pump orders to be able to include the medication in their monthly drug regimen review. Pharmacy will be updated with any medication or dosage changes.
- E. RN Manager or designee to implement or update resident's care plan to reflect the pain pump use and care
- F. In the event of actual signs/symptoms of complications to the pain pump or signs/symptoms of side effects to the pain pump medication or alarm sounding **IMMEDIATELY** contact the resident's primary physician and the clinic that manages the resident's pain pump.

3/2012

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IMPLANTED PAIN PUMP ORDER SHEET

1. Implanted Pump Information: Pump type and site: _____
 2. Pump Insertion date: _____
 3. Medication and Dose including concentration and diagnosis:

 4. Type of Pump alarm: _____
 5. Alarm Date: _____ Alarm setting: _____
 6. All implanted pain pump dose adjustments, reservoir changes, refills, alarm settings, rate changes will be managed by the medical staff and/or designees at: _____
 7. Contact information for clinic managing pump:
Phone number: _____ After-hours phone number: _____
 8. Next Pain pump appointment: _____
 9. After each pain pump appointment update pump information via MD orders include: concentration, rate, alarm date and alarm setting.
 10. After, clinic appointment: Document time of return. Remove dressing 1 hour after return if present and monitor for bleeding, fluid leakage, increased abdominal pain distention. LN to doc 'Y' if no s/sx noted are present, doc 'N' if s/sx select 9 'other/see progress notes' and progress note findings and document s/sx & also notify MD and pump clinic.
 11. Monitor implanted pump site QD for redness, irritation, drainage, swelling, pain. LN to doc 'Y' if no s/sx are present. Doc 'N' if s/sx present select chart code 9 'other/see progress notes' and progress note findings. Notify MD and pump clinic.
 12. Monitor QD for s/sx of implanted pump complications: infection, fever, tachypnea, tachycardia, malaise, altered mental status, sudden severe back pain, loss of bowel and bladder control, s/sx of meningitis, sudden onset of leg weakness or spasm, kinking, coiling, or breaking of catheter, battery failure. Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
 13. Monitor QD for s/sx of _____ under dose/withdrawal: _____
_____ Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
 14. Monitor QD for s/sx of _____ overdose: _____
LN Doc 'Y' if no s/sx noted doc 'N' if s/sx present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
 15. Alarm monitor: Auscultate over pump site QD to assess for alarm sound. LN to Doc 'Y' no alarm sound is present. Doc 'N' if alarm sound is present, select chart code 9 'other/see progress notes and progress note findings. Notify MD and pump clinic.
- *Copy of these orders to be given to pharmacy

Nurse Signature: _____ Physician Signature: _____

Resident Name: _____ Physician: _____ Date: _____

CPR CERTIFICATION FOR LICENSED NURSES

1. To ensure that CPR-certified staff are available at all times, licensed staff must maintain their Basic Life Support (BLS) for Healthcare Providers (HCP) certification through training that includes hands-on practice and in-person skills assessment. Newly hired licensed staff that does not have a current BLS for HCP certification will have four months to obtain certification.
2. CPR for HCP classes are provided in-house quarterly to employees of the Idaho State Veterans Home – Boise (ISVH-B) free of charge by a BLS instructor certified through the American Heart Association (AHA).
3. ISVH- Boise employees will be paid for their time when attending the in-house AHA BLS for HCP course.
4. If an employee does not wish to attend, or misses the in-house CPR education provided, they may attend a class outside of the facility on their own time and at their own cost. This class must meet the requirements of CPR training that includes hands-on practice and in-person skills assessment. Online certification is not acceptable.
5. Licensed nurses are responsible for maintaining their current CPR card. If the licensed nurse attends the in-house training, the Staff Development Coordinator (SDC) will make a copy of the certification and give the original CPR card to the staff member. If the licensed nurse attends a class outside of the facility, they will be responsible for providing a copy of the certification to the SDC. The SDC will maintain a record of card expiration dates for the licensed nurses.
6. The copy of the current CPR card will be placed in the ISVH Employee Credentials binder.

05/15, 12/17, 08/18

USE OF T/PUMP LOCALIZED TEMPERATURE THERAPY SYSTEM (K-PAD)

Description:

The purpose of this procedure is to provide a reliable process for the proper operation and maintenance of the **T/Pump®** Localized Temperature Therapy system (K-PAD). The **T/Pump®** Localized Temperature Therapy system delivers temperature-controlled water. Water temperature increases with the use of the heater. Water temperature decreases with the use of ice. The system delivers and removes thermal energy to and from the local anatomical sites. This occurs at the contact point of the patient skin and thermal transfer device to raise or lower the temperature of local anatomical sites.

Guidelines:

1. This is for the application of temperature therapy in situations where a physician determines that temperature therapy is necessary.
2. For use in healthcare settings and home use. The use of this device will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care.
3. Facility staff will provide appropriate assistance to ensure that the resident can use this device. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed.
4. Direct care staff will be trained on the use of this device as needed to carry out their roles and responsibilities regarding the device. Training will also include when to refer to other departments for changes in condition or problems with the device.
5. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.

To start the pump:

- Before filling the pump reservoir, attach a pad to the connector hose, make sure that there are no kinks in the hose or pad.
- Open the hose clamps.
- Open the fill cap on the top of the pump.

To fill for cooling

- Fill with cold water to the Cooling water line.
- Fill with ice to the full capacity of the reservoir.

Note: When using the pump for cooling, the ice will eventually melt and the setpoint will start flashing.

To fill for heating

- Fill with room temperature water to the heating water line.
- Plug the pump into a properly grounded hospital grade wall outlet.
- Press the On/Standby button. The light next to the selected temperature begins to flash.
- Use the keypad to set the temperature as directed by the physician.

Note: After setting the temperature, press and hold the Setpoint lock button for two seconds to lock the setpoint. If you go past the desired setpoint, keep pressing the button to start at the beginning of the setpoint values. It takes about 15 minutes to reach the selected water temperature. The light next to the selected temperature becomes steady. Check the water level. If the water level drops below the operating level, add water.

- Apply the Mul-T-Pad to the patient as directed by a physician.
- Position the pump at or above the level of the pad.

Note: Do not place the pump below the pads, water will drain into the pump during shut off. If the pump has been overfilled or if you connected multiple pads, excess water can leak.

To start therapy cycles:

- Press the **On/Standby** button to turn the pump on.
- Set the temperature setpoint. The unit will start to heat up.
- Select the warming period for a 20 minute or 30-minute cycle.
- The LED turns solid and the selected temperature LED flashes.

Notes: The red warming LED flashes with a short audible beep to inform the operator the unit is at the set temperature. The timed therapy is starting. When the 20 minute or 30-minute time period is completed, the heater and pump shut off. The water flow to the pads is stopped. The setpoint and therapy time LEDs blink to indicate the off-time period. After the off-time period is completed, the pump and heater restart. The time therapy LED goes solid and the setpoint LED flashes. After the setpoint is reached, the red LED flashes with a short audible beep to let the operator know the next therapy cycle has started.

Stopping the pump:

- Press the **On/Standby** button. The standby light illuminates.
- Unplug the product.
- Close all of the hose clamps.
- Disconnect the pads from the pump.

Note: To prevent water spillage, always raise the connections above the level of the pad and the pump before disconnecting the pad from the pump.

- Coil the hose and attach the **Clik-Tite** connectors together on the hose.
- Secure the hose to the pump by using the tube set strap.
- Wrap the power cord around the product.

Storing the pump, short term: Short term storage is less than one day.

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- Close the hose clamps.
- Disconnect the pads.
- Connect the ends of the connector hoses together, where applicable.
- Open the hose clamps.
- Leave water in the reservoir.
- Coil and fasten the hose using the tube set strap and wrap the power cord around the product.
- **Note:** Change the water monthly or more often depending on use.

Added 04/19

References

Stryker. (2017, October). Stryker T/Pump. *T/Pump® Series Localized Temperature Therapy System Operations Manual*. Portage, Michigan, USA. Retrieved from Stryker Patient Handling.

CLEANING OF T/PUMP LOCALIZED TEMPERATURE THERAPY SYSTEM (K-PAD)

Description:

The purpose of this procedure is to provide a reliable process for the cleaning of the **T/Pump®** Localized Temperature Therapy system (K-PAD).

Guidelines:

Draining the pump

- Disconnect the pump from AC power.
- Clamp the hose clamps.
- Disconnect the pads or hoses from one another, keep the hoses at or above the level of the pump.
- Open the hose clamps.
- Remove the fill cap and invert the pump over a sink to drain.
- Replace the fill cap after all of the fluid has drained from the hoses and reservoir.
- Connect the ends of the connector hoses together, where applicable.

Cleaning the external surface

Recommended cleaning agents include:

- A clean damp cloth and mild soapy water
- Phenolic disinfectant or 10% bleach solution

To clean the external side of the pump:

- Unplug the controller.
- Wipe the outside of the product with the following:
 - Using a clean, soft cloth moistened with a mild soap and water solution to remove foreign material
 - Using a clean, soft cloth moistened with a phenolic disinfectant or 10% bleach solution.
- Follow specified contact time in accordance with the manufacturer's instructions for use.
- Using a clean, soft cloth, wipe the outside of the product with water.
- Dry the external surface with a clean, dry cloth.

Cleaning the water circuit and hose

Tools Required:

- Disinfectant Cleaner 2.0 (8001-999-333)
- Personal protective equipment, based on cleaning agent manufacturer's instructions
- Soft, lint free cloth (2 or more)

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- Prepare a germicidal solution according to the manufacturer’s instructions for the Disinfectant Cleaner 2.0.
- Drain the pump.
- Connect the hose set together, where applicable, or attach a pad to the connector hose.
- Fill the reservoir to the heating water line on the back of the reservoir.
- Select 95° F (35° C) temperature on the keypad.
- Press the **On/Standby** button to start the pump.
- Circulate the solution for one hour.
- Drain the solution from the reservoir.
- Rinse and drain the reservoir with water
- Dry the reservoir inside and outside with a dry, lint free cloth.

Added 04/19

References

Stryker. (2017, October). Stryker T/Pump. *T/Pump® Series Localized Temperature Therapy System Operations Manual*. Portage, Michigan, USA. Retrieved from Stryker Patient Handling.

TUBE FEEDING SKILLS CHECK LIST

Employee Name _____

SKILL	YES	NO	COMMENTS
Does the order state (1) type of feeding (2) amount to be administered with each feeding (3) times of each feeding (4) rate of flow (5) type of flow (gravity/pump) (6) diagnosis requiring tube feeding (7) amount of free water with each med/feeding/flush (8) calories from each feeding			
Is resident properly positioned to receive enteral nutrition? (e.g. head elevated 30+ degrees)			
Is the amount to be fed the resident consistent with the order?			
Is the tubing dated? Is the irrigation syringe dated?			
Are the equipment/feeding cans/bags stored appropriately? (Only clean surface in a room is a paper towel)			
If cans are used, did the nurse wipe down prior to opening?			
Did the nurse obtain residuals prior to beginning tube feeding?			
Did the nurse check for proper tube placement prior to beginning the tube feeding?			
Did the nurse flush before and after the medications/feedings? (with at least 30 cc warm water)			
Did the nurse assess/document tube insertion site?			
Did the nurse monitor for feeding complications such as diarrhea, gastric distention, aspiration?			
Is the flow rate consistent with the order/consistent with proper tube feeding technique?			
Does the documentation include the amount of free water used in the flush?			

Signature of Nurse Evaluator

Date

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ABNORMAL INVOLUNTARY MOVEMENT (AIMS) SCALE TESTING 4

NURSING HOME SOCIAL WORK PROCEDURE

Please refer to the Social Service Procedure Manual for the following:

- Admissions
- Clinical Pre-Admission Assessment Form
- Advanced Directive
- Notice of Bed-Hold Policy
- Comprehensive Care Plan and Care Conference
- Documentation
- Family Council
- Missing Items
- Prevention Program for the Management of Challenging Mood and Behavioral Symptoms
- Referral Forms
- Referrals to Other Departments
- Referral to Community Based Resources Outside of the VA System
- Reminiscing Groups
- The Resident Abuse Prevention Program
- Social Service Department Meetings
- Social Services Staff Training

SOCIAL SERVICES – NURSING UNIT SERVICES

Purpose

To ensure each of our residents receive medically related social services at a level to attain or maintain their highest practicable physical, mental, and psychosocial wellbeing.

Procedure

1. A social worker shall be specifically designated to each unit of the skilled nursing facility to provide services consistent with state and federal regulations, facility policies and procedures, and other guidelines as mandated.
2. A social worker shall work with the unit's RN Manager to determine appropriate coverage for residents' needs/services.

10/00

ABNORMAL INVOLUNTARY MOVEMENT (AIMS) SCALE TESTING

Purpose

To assure that residents who are undergoing neuroleptic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on the following:

- Tardive dyskinesia
- Postural (orthostatic) hypertension
- Cognitive/behavior impairment
- Akathisia
- Parkinsonism

Procedure

1. Testing - the social services department (social worker), in cooperation with the nursing staff, will complete AIMS testing at the scheduled time(s). This assessment to be done in residents Assmnt. Tab of Point Click Care (PCC). Assessment is called AIMS – Abnormal Involuntary Movement Scale.
2. Testing Schedule
 - a. Ongoing Testing: All individuals currently taking neuroleptic medication shall be assessed at least once every six (6) months or more frequently as necessary by symptom assessment or determined by the prescribing practitioner.
 - b. Upon Admission: Any resident currently taking neuroleptic medication who is newly admitted to ISVH-B shall have an initial screening within one month of admission.
 - c. Increase or Decrease of Neuroleptic Medications:
 1. Within one (1) month but not before seven days following the increase or decrease of the medication.
 2. Every six (6) months thereafter.
3. Discontinuance: Any resident whose neuroleptic medication is discontinued shall be screened after the discontinuation at the following intervals:
 - a. One (1) month
 - b. Three (3) months, or
 - c. Whenever the prescribing practitioner determines and documents that the individual does not have TD.
4. Individuals showing signs of TD will be referred to the physician for the purpose of evaluation, diagnosis, and treatment recommendations.

08/02, revised 02/03, 11/14

LABORATORY REFRIGERATOR LOG

NOTE: Temperature should be within the range of 36-46 degrees; temperatures not within this range must be reported to the RN Unit Manager.

Unit: _____

Month/Year: _____

Day	Temperature (Fahrenheit)	Comments/Adjustments	Nurse Initials
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
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30			
31			

Revised 06/15, 02/17; Reviewed 12/15

MEDICATION AND TREATMENT ERRORS AND OMISSIONS ADVERSE DRUG REACTIONS

Resident's Name: _____ Room: _____
 Date of Occurrence: _____ Physician Notified: _____ Supervisor Notified: _____
 Family/Legal Representative notified: _____
 (Notification needs to be done immediately upon the discovery of error.)

MEDICATION AND TREATMENT

Name of Nurse making error/omission: _____

Notified:

Medication (and dose) involved: _____

Describe error/omission (list med(s) involved): _____

How discovered: _____

Effect on resident: _____

Possible harmful effects: _____

CAUSE(S) OF ERROR(S) - Check all that apply:	TYPE OF ERROR – Check all that apply:
Identification of resident	Wrong Medication:
Didn't check med label with MAR	Wrong dose
Didn't check route of administration	Wrong day/time
Didn't check that resident took meds	Wrong resident
Error in Charting	Med Omitted
Incorrectly Charted	Other (explain) :
COMMUNICATION FAILURE:	
___ Order not transcribed correctly	
___ Not read correctly	
___ Verbal order not heard correctly	Nurse Signature:

ADVERSE DRUG REACTION

DRUG IDENTIFIED AS POSSIBLE CAUSE OF REACTION: _____

Describe adverse reaction: _____

Describe intervention: _____

Care Plan updated: _____ Drug Allergy noted on chart (if applicable) _____

Signature of person reporting adverse drug reaction: _____

(Route to Unit RN Manager)

MEDICATION REFRIGERATOR LOG

NOTE: Vaccine must be stored at between 36 and 46 degrees (2° C & 8° C). Refrigerator temps greater than 46 degrees or less than 35 degrees must be reported to RN Unit Manager and medication moved to appropriate alternate refrigerator. Contact maintenance ASAP, contact pharmacy for further instructions on safety of medications.

TEMPERATURE (FAHRENHEIT)							Comments & Adjustments
Day	Days / Initials		Eves / Initials		Nocs / Initials		
1							
2							
3							
4							
5							
6							
7							
8							
9							
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25							
26							
27							
28							
29							
30							
31							

Unit: _____ Month/Year: _____

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PHARMACY SERVICES

The Idaho State Veterans Home – Boise 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.

1. The pharmacist shall be responsible for:
 - a. Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admission or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation.
 - b. Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues.
 - c. Reviewing all medications in the facility for expiration dates.
 - d. Removal of discontinued or expired drugs from use as indicated at least every thirty (30) days.
 - e. 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.
 - f. Reviewing the narcotic and dangerous drug records at least every thirty (30) days and certifying to the administrator that the inventory is correct.
 - g. 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.
 - h. Providing the administrator, on a quarterly basis, a written report of services and activities done at the facility with any recommendations.
2. 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.

Reviewed 12/15; Revised 08/17

DRUG DISPENSING TO FACILITY

Medication Labeling/Cassettes

1. Medications will be dispensed throughout ISVH-B using the bubble pack system or from individually labeled bulk bottles.
2. All medications (bubble pack) will be labeled with the name and strength of medication, manufacturer's name, lot identification number, expiration date, and initials of pharmacist dispensing.
3. All other medication containers that cannot be unit dosed will be labeled with the name of the medication, lot identification number, expiration date, and initials of pharmacist dispensing and if dispensed for a particular resident, their name will appear on the label.

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.
2. Removal of any drugs from the Pharmacy by an authorized nurse must be recorded on a suitable form showing name of drug, strength, amount, date, time, resident's name and nurse signature.

Revised 10/02, 12/15

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 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 re-stocking as necessary.
6. The pharmacist will be responsible for replacement and disposal of expired medications.

Revised 10/02, 12/15

STANDING INFLUENZA TESTING & RESPONSE INTERVENTIONS

Purpose:

To ensure a sustainable healthcare response to an influenza outbreak.

Procedure:

1. a. If a resident has at least 3 of the following symptoms: fever or feeling feverish/chills; muscle or body aches; cough, sore throat, new or worsened chest congestion (not stuffy nose), new or acutely worsened delirium/confusion AND influenza is known to be present in the community; licensed nurse shall perform a CLIA Waved Quick Vue Influenza A & B test or Binax Now Influenza A & B (per instructions located in each unit's Med Room).

OR

- b. Obtain a new physicians order for influenza rapid test.
2. Document results of Influenza A & B Rapid Test on the "Influenza A & B" report and notify MD.
3. If the resident's test is positive for **Influenza A,** the licensed nurse shall:
 - a. Contact the resident's family or legal representative related to the test results/interventions.
 - b. Contact the resident's physician to obtain order for Tamiflu (refer to d.)
 - c. Isolate resident either in a private room or in a room with a previously tested positive resident until the final culture results are obtained and/or the resident's fever has subsided, and the course of treatment completed. (Resident shall not venture into common areas during this isolation period. Refer to Isolation Procedure related to Influenza)
 - d. Per physician's order start resident on Tamiflu 75 mg. i capsule BID by mouth x 5 days unless there is a known allergy to Tamiflu.
4. In the event of a positive QuickVue or Binax Now test, the licensed nurse shall notify the RN Unit Manager of the unit in which the resident resides, the Staff Development Coordinator, the Infection Control Nurse and the Director of Nursing Services of the name of the resident and the actions taken.
5. All interventions and communications shall be documented in the specific resident's medical record, the care plan updated, and the resident put on Alert Charting.

12/12, Revised 01/15, 12/15

NOVEL INFLUENZA TESTING & RESPONSE INTERVENTIONS

Purpose:

To ensure a sustainable healthcare response to a Novel Influenza outbreak.

Procedure:

1. If a resident has symptoms which suggest the possibility of Novel Influenza e.g. increased temperature, body aches, sore throat, cough - licensed nurse shall obtain a CLIA Waved QuickVue Influenza A & B test or Binax Now Influenza A & B (per instructions located in each unit's Med Room).
2. If the resident's test is positive for **Novel Influenza** the licensed nurse shall:
 - a. Immediately obtain cultures from the resident per instructions on the influenza (VTM) culture kit and store/preserve culture per instructions and complete the Novel Influenza Virus, surveillance form to accompany test to lab.
 - b. Notify facility's contract laboratory service related to the culture and request pick-up as soon as possible.
 - c. Contact the resident's family or legal representative related to the test results/interventions.
 - d. Contact the resident's physician to obtain order for culture and Tamiflu (refer to f.)
 - e. Isolate resident either in a private room or in a room with a previously tested positive resident until the final culture results are obtained and/or the resident's fever has subsided, and the course of treatment completed. (Resident shall not venture into common areas during this isolation period. Refer to Isolation Procedure related to Influenza).
 - f. Per physician orders start resident on Tamiflu 75 mg. 1 capsule BID by mouth x 5 days unless there is a known allergy to Tamiflu.
3. In the event of a positive QuickVue or Binax Now test, the licensed nurse shall notify the RN Unit Manager of the unit in which the resident resides, the Staff Development Coordinator, and the Director of Nursing services of the name of the resident and the actions taken.
4. All interventions and communications shall be documented in the specific resident's medical record, care plan updated, resident put on Alert Charting.

5/09, Revised 12/12, Reviewed 12/15

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IDAHO BUREAU OF LABORATORIES
2220 OLD PENITENTIARY ROAD
BOISE, IDAHO 83712
SWINE-ORIGIN INFLUENZA A(H1N1) VIRUS (S-OIV) SURVEILLANCE
Testing Criteria and Submission Form 2009

Clinical, Epidemiologic, and Public Health Notification Criteria
OEFP* will give priority to specimens from patients meeting the following criteria:

Clinical Criteria:

- Influenza-like illness (ILI), defined as a fever and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza, AND

Epidemiologic Criteria: at least one box must be checked

- Onset of illness within 7 days of close contact with a person who is a confirmed case of S-OIV infection, OR
- Onset of illness within 7 days of travel to community either within the United States or internationally, where there are one or more confirmed cases of S-OIV infection, OR
- Hospitalization with ILI

Public Health Notification:

- Local Health District or State Division of Health has been notified of suspected case.

Patient Information	First name:	Last name:
DOB:	Age:	Gender:
Patient ID#:	Sample collection date:	
County of Residence:	Onset date:	
Sample type: <input type="checkbox"/> NP swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Other	Has patient been tested with rapid kit? No <input type="checkbox"/> Yes <input type="checkbox"/> Pos A <input type="checkbox"/> Pos B <input type="checkbox"/> Neg <input type="checkbox"/>	
Has patient had antiviral treatment within the last month? No <input type="checkbox"/> Yes <input type="checkbox"/>		
If yes, which one:		
Has patient traveled within the last 7 days? No <input type="checkbox"/> Yes <input type="checkbox"/> Traveled to:		
Clinic/Hospital:		
Doctor:		
Address:		
Phone #:		
Copy to:		
Address:		
Phone #		

For free shipping call 208-334-2235 x 228/230/272. S-OIV testing for approved specimens is free of charge. Samples testing positive for influenza A, but unsubtypeable as seasonal influenza, will automatically be forwarded to CDC for S-OIV testing or tested further by IBL as in-state reagents become available.

* OEFP: Idaho Department of Health and Welfare, Division of Health, Office of Epidemiology and Food Protection

Last updated: 4/29/2009

Reviewed 12/15

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 Carts

1. Medications will be passed directly from cart drawers.
2. No medications will be “stored” on the top of the medication cart.
3. No medications will be set up prior to administration.
4. Medication carts will be kept locked when not in use.
5. All fluids and food used for medication pass will be dated and covered.
6. All food/fluids requiring refrigeration will be stored in proper container and discarded at the end of each med pass.
7. To protect the resident’s right to privacy, the nurse will lock the computer screen when away from the cart.
8. Medications that have been set-up and not given or refused (also refer to Controlled Substance Administration and Disposal) shall be wasted.

Medication Administration

1. Nursing’s process (six rights) will be noted before the administration of each medication.
 - a. Right resident
 - b. Right medication
 - c. Right dose
 - d. Right route
 - e. Right frequency
 - f. Right documentation
2. Medications shall not be touched.
3. Alcohol hand sanitizer shall be used after approximately every five (5) medication passes or as needed.
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 five (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 Administration Times and Orders

The facility will administer medications and treatments to residents per provider’s orders with the outlined flexible administration times to allow for resident centered, individualized care.

DOSING INTERVAL	HR	HR	HR	HR
AM MED PASS	0600-1000			
NOON MED PASS	1100-1300			
PM MED PASS	1500-1800			
HS MED PASS	1900-2300			
NOC MED PASS	2330-0600			
SNACKS	1000	1500		2000

*In collaboration with physician, the nurse may change standard medication times to accommodate resident preference and notify the Unit Clerk.

QD medications will be administered AM, unless they are ordered otherwise, or in below exceptions.

QPM medications will be administered PM

BID medications will be administered AM and PM

TID medications will be administered AM, NOON, and PM. **QID** medications will be administered AM, NOON, PM and HS

- Medications administered with a greater frequency than QID will require a medical provider to specify administration times.
- If a medical provider specifies a time when a medication is to be administered, that specific time will be honored.
- If determined by the consulting pharmacist that a specific medication needs specific dosing times due to pharmacokinetics, medication interactions, laboratory needs, or any other concerns; those times will be honored.

Blood Glucose Monitoring:

0630	FSBG will be monitored prior to morning meal consumption
1030	FSBG will be monitored prior to noon meal consumption
1530	FSBG will be monitored prior to evening meal consumption
2000	FSBG will be monitored at bedtime

1. All physician's orders including telephone (TO) and verbal orders (VO) shall be written by a licensed nurse, pharmacist, or physician on the multi-layer Physician's Order form.
2. All TOs and VOs shall be countersigned by the resident's primary physician.
3. Medication order shall include the resident's diagnosis, the name of the medication, the route to be given, the dose and frequency to be administered.
4. On all TOs/VOs the nurse writing the order shall complete, in addition to the actual order (per above), the entire bottom section of the order form.
5. Nursing staff is responsible for verifying that the order has been entered correctly into Point Click Care (PCC) and scheduled appropriately for the eMAR/eTAR either by entering the order in themselves or the Unit Clerk may input the order. If the Unit Clerk has entered the order, the order will be "pending confirmation". An order that is pending confirmation is not active in PCC until review by the licensed nurse. The licensed nurse will review the order, 'confirm' and then 'acknowledge' the order, which will then make the order 'active' in PCC.
6. In addition to noting the order, the nurse shall indicate “pulled” on the white copy of the multi-layer physician's order for any medication that has been changed or discontinued.
7. Licensed nurse noting the order shall remove the specific (decreased or dosage changed) medication from the med cart and deposit in med room. (Note: If the medication is a controlled substance, contact pharmacist for proper disposal.)

Medication Administration Documentation:

1. The nurse will compare the medication label to the eMAR/eTAR, then remove the medication from the container or blister in preparation for administration. The nurse will then click on 'Y' in the PCC eMAR. This is the equivalent to placing a dot or small (✓) on a paper MAR/TAR.
2. Medications will be signed off **after** being given. This is done by clicking on the 'Save' button in eMAR/TAR in PCC.
3. PRN medications will be charted in PCC on the specific PRN medication order in eMAR/TAR with reason and results being documented in a progress note. PCC prompts a progress note with administration of any PRN medication.
4. When a resident refuses a medication, the nurse will change the 'Y' to a 'N' prior to saving the administration. The nurse will then explain the reason for refusal in both the Administration Details and Progress Notes section for the specific medication. After documenting the reason for refusal, then the nurse will click on the 'Save' button in the eMAR/TAR.

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5. Injections will be charted with site of injection (also refer to Insulin Injection Site Documentation).
6. When a medication is not given within one hour of the specific scheduled time or within the broadened medication pass time, then the nurse will document a progress note as to the reason for the late administration. This is done for all medications except PRN narcotic medication. PRN narcotic medication must be given at time frame specified by the MD order.
7. If a medication is not administered for a reason other than refusal, the nurse will document 'N' in PCC eMAR/TAR, explain the reason in Administration Details and Progress Notes for each medication not administered, then the nurse will click the 'Save' button in the eMAR/TAR
8. 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 03/04, 04/06, 02/07, 02/08, 12/08, 8/11, 10/13, 11/14, 12/15, 02/17

PATIENT CONTROLLED ANALGESIA (PCA)

Purpose:

To provide guidelines for safe and effective administration of pain medication and the care of a patient receiving patient-controlled analgesia medication via a continuous ambulatory infusion pump.

Procedure:

1. Preparation

- a. The facility interdisciplinary team will assess resident to determine if he or she is an appropriate candidate for patient-controlled analgesic by taking into consideration the patient's mental status, cognitive function, ability to understand and follow directions, physical dexterity, level of sedation, level of pain and respiratory function.
- b. Obtain a physician's order for patient-controlled analgesia. The order will include:
 - i. Medication
 - ii. Medication concentration
 - iii. Infusion rate
 - iv. Route and Mode of delivery
 - v. Basal rate
 - vi. PCA dose and lockout interval
 - vii. Four-hour limit
- c. RN Manager or designee will complete in the resident's electronic medical record. (EMR)
 - i. BVH – Pain Assessment, located in the ASSMNT tab of PointClickCare (PCC)
 - ii. BVH- Self Administration of Medication Assessment, located in the Assmnt tab of PCC EMR.
- d. RN Manager or designee will review and update resident's Plan of Care to include PCA in Care Plan tab of PCC.
- e. The facility will have supplemental oxygen and an opioid antagonist (naloxone) on hand. Obtain physician's order as needed to administer.

2. Procedure

- a. Gather equipment and supplies
 - i. Initiate and maintain subcutaneous access
 1. Dressing change to SQ insertion site per MD orders
 2. Monitor SQ insertion site per MD orders
 - ii. Refer to the equipment manual for specific PCA pump model being used for directions on set-up and operation.
 1. Upon initial set-up of PCA pump, after a pump refill, or after a programming change two clinicians (RN, LPN, Pharmacist) will double check the following:
 - a. The name of the resident

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- b. The drug being administered
 - c. The concentration
 - d. PCA pump settings
 - e. Line attachment
 - f. Settings on pump are locked to prevent unauthorized changes.
2. Every PCA cassette containing narcotic medication will use a separate PCA Narcotic Use Record Sheet to maintain accurate narcotic count.
- a. PCA Narcotic Use Record Sheet for the PCA cassette in use will be documented at shift change by two nurses. documentation will include:
 - i. Date
 - ii. Time
 - iii. Dose and concentration
 - iv. Basal Rate (mg/hr)
 - v. Remaining cassette volume in ml
 - vi. Total used for the off going shift in ml
 - vii. # of PCA Bolus used by resident in ml
 - viii. PCA Bolus Delay between doses in minutes
 - ix. # of PCA bolus attempts made by resident
 - b. Provide the resident and family/responsible party education before the PCA is administered. Education will include the following:
 - a. Description of PCA
 - b. Resident and family role in pain management
 - c. Pump operation; how to activate a PCA dose, safety features of the pump such as lock out intervals and time-dose limits.
 - d. The dangers of anyone other than the patient activating a PCA dose
 - e. What to expect in terms of patient monitoring and frequent assessments
 - f. Potential side effects of narcotic analgesia
 - g. When to alert the nurse
 - c. Changing the PCA cassette or adjusting dose setting
 - i. Review physician's order to confirm type and amount of medication, route, rate of administration and PCA bolus parameters
 - ii. With a second clinician (nurse or pharmacist)
 1. Check and sign off the PCA Narcotic Use Record to reflect dose adjustment or change of cassette
 2. Verify identity of resident
 3. Inspect the cassette/medication for leaks, cracks, precipitate and expiration date

4. Insert the new cassette or adjust pump settings and have second nurse verify
 5. Label all tubing
 6. Start the infusion
- d. During the use of the PCA
- iii. Monitor the resident for pain, signs and symptoms of overdose, withdrawal
 - iv. Document the narcotic administration in the eMAR and on the PCA Narcotic Use Record
 - v. Notify MD of any refusal of medication or treatment, new or increasing pain, increased sedation, respiratory depression or other side effect of medication such as constipation, nausea, itching, etc.

3. Discontinuation of PCA Pump

- a. Obtain a physician's for discontinuation of PCA Pump
- b. Remove infusion needed from resident and document resident status and toleration of procedure
- c. Remove all PCA pump equipment from resident room
- d. Notify Pharmacy to destroy the remaining narcotic medication, until it is destroyed the narcotic must remain locked per facility procedure (double locked) and included in the narcotic count.

07/15, Reviewed 12/15

NUTRITIONAL AND DIETARY SUPPLEMENTS

Procedure:

It is the policy of this facility that nutritional and dietary supplements will be used to complement a resident's dietary needs in order to maintain adequate nutritional status and resident' highest practicable level of well-being.

Definitions:

“Dietary Supplements” refers to herbal and alternative products that are not regulated by the Food and Drug Administration and their composition is not standardized.

“Nutritional Supplements” refers to products that are used to complement a resident's dietary needs such as calorie or nutrient dense drinks, total parenteral products, enteral products and meal replacement products (e.g., Ensure, Glucerna, Promote).

Procedure Explanation and Compliance Guidelines:

1. Resident's nutritional status will be accurately and consistently assessed upon admission and on an as needed basis to identify a resident at nutritional risk and address risk factors for impaired nutritional status.
2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs.
3. All herbal and alternative products that are not regulated by the FDA are to be considered as dietary supplements.
4. Dietary supplements are to be labeled as dietary supplements.
5. Dietary supplements that are given between meals and contain vitamin(s) as one or more of its ingredients should be documented and evaluated as a dietary supplement, rather than a medication.
6. Due to possible interactions with some medications, the resident's intake will be documented in the clinical record.
7. The facility staff will monitor for any adverse reactions between medications and nutritional and dietary supplements the resident is receiving.
8. Nutritional supplements are to be provided to residents within 45 minutes of either a resident's request or less depending on the facility's scheduled time for meals.
9. Supplements may be provided by a dietitian recommendation as allowed by physician standing order.
10. The care plan will be updated with the new or modified nutritional interventions.

References

1. Centers for Medicare & Medicaid Services, Dept. of HHS. Appendix PP: Guidance to Surveyors for LTC Facilities; State Operations Manual (SOM) 42 C.F.R. 483.25(g) F-692.
2. Centers for Medicare & Medicaid Services, Dept. of HHS. Appendix PP: Guidance to Surveyors for LTC Facilities; State Operations Manual (SOM) 42 C.F.R. 483.60(a) F-802

Added 9/2019

HOLDING MEDICATIONS

Purpose

Medications, as ordered by each resident’s physician, are administered in accordance with the Standards of Nursing Practice and other state rules and regulations governing medication administration. The administration of any medication must be in accordance with the following:

Procedure

All medications must be administered by the licensed nurse in the correct dosage within the timeframes/frequency/route as ordered by a physician. If a medication is ordered and not given, then the licensed nurse shall immediately notify the physician with the rationale for the decision and to obtain further instructions.

Any HOLD of a medication will ONLY occur under the following circumstances:

1. Upon receipt of an order for a medication, the licensed nurse or other party recognizes a **potential for** the resident to experience an **adverse drug reaction** if given the medication e.g. allergies, previous similar problems with this medication or similar acting medication, etc. Upon or prior to the administration of the medication if the nurse identifies an adverse reaction to the medication or the potential for an adverse drug reaction and “HOLD(s)” medication then the physician shall be contacted for further instructions.
2. The medication to be administered **has parameters for use** e.g. “do not give if HR <65” or “do not give if B/P S <100” etc. and consequently the medication is “held” or not given per the parameters. Rationale is documented on the eMAR – follow-up with the physician in this scenario does not need to occur unless it becomes a pattern for the resident and the physician should then be contacted for a change the dosage, discontinue the medication, etc.
3. The medication may or was administered in another facility, by another nurse, by a family member, too short a timeframe from the last dose given, etc. Rationale for holding the medication (due to **duplication**) needs to be documented on eMAR and the physician notified in a timely manner through the communication book, phone call, Medication Error report, etc. depending on medication and the criticality of the situation.
4. **Resident refuses** the medication or is **out of the facility** during the scheduled times of administration. Documentation related to the refuses or absence of the resident shall be documented in the eMAR. No physician contact is typically required in these instances until the resident continually refuses or the refusal of the medication imposes an imminent danger to the health of the resident.
5. Holding **insulin or other hyperglycemic medications** will be in accordance with the specific procedure – reference “Treatment of Hypoglycemia” procedure located elsewhere in the Nurse Procedure Manual.

07/08, Revised 11/14, Reviewed 12/15

INJECTION & 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 eMAR (Electronic Medication Administration Record).
 - a. Licensed staff will document 'Y' in the appropriate time/day/shift "box" in the eMAR after the medication is administered.
 - b. Licensed staff will indicate in the appropriate site of location in the eMAR for the injection site and/or placement site of the dermal patch. It is anticipated that the injection/placement site will rotate among the appropriate sites.

11/00, Revised 11/14, Reviewed 12/15

MEDICATION RECALL

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.

1. Any noted medications found will be returned to the ISVH-B pharmacy.
2. 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).
3. The Pharmacist will notify the Medical Director with the information.
4. All residents who received the medication will be assessed by the provider for any possible complication(s) the recalled medication may have caused.

Revised 10/02, Reviewed 12/15

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. Medications will be disposed of based on the manufacturer's expiration date, regardless of the date the medication was put into service (exceptions e.g. insulin shall be destroyed twenty eight (28) days after opening).
6. Poisons and toxic chemicals shall be stored in separate locked areas apart from medications.
7. 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.

10/02, Revised 4/06, 12/15 Reviewed 08/14

MEDICATION / PRESCRIPTION ORDERING AND RE-ORDERING

Pharmacy cycle fills the Rx on each unit for a 30-day supply of resident medications.

Medications with perimeters of x number of days, (such as an antibiotic for 10 days), will be filled for the prescribed days/dose.

With new prescriptions that are ordered during the middle of the fill cycle, pharmacy will fill the prescription with enough medications to give through the current cycle.

Medications that **will not** be cycle filled and will need to be reordered when you run out:

- Warfarin
- Controlled medications (in the locked drawer)
- Insulin
- Eye drops
- Ear drops
- Nebulizer
- IV medication
- Liquid medication
- Bulk Med
- Floor Stock

The reorder procedure for medications that are not cycle filled are as follows:

1. Write the residents name and RX number on the refill order sheet located in the pharmacy box on the unit.
2. If, after a reasonable time (1-3 days), the medication has not been refilled, please notify the pharmacist unless needed sooner.

Every nurse is responsible for reordering the meds that are not cycle filled in a timely manner prior to using last dose.

Stock floor meds are ordered using the Floor Stock Re-Order List located in the pharmacy box on the unit.

New orders are filled by placing the printed prescription page of the Dr.'s order in the pharmacy box and calling the pharmacist ASAP to let them know a new order is ready to be picked up and filled.

New admission orders are faxed to the pharmacist to be filled.

8/02, Revised 11/12, 05/14, 12/15, 04/16

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 topicals)	10 days
Anticoagulants	30 days
Schedule II	30 days
Schedule (other)	30 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. Unit RN Manager (or designee) will initiate the physician notification and discontinuation order.

Revised 10/02, Reviewed 12/15

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.

Floor stocks of narcotics and controlled substances

1. Floor stocks of controlled substances and narcotics will be inventoried by the licensed nursing staff and ordered from the pharmacy by the unit's RN Manager.
2. The Pharmacist will make any necessary adjustments on the narcotics sign out sheet and the narcotics inventory book.

Controlled Substance Inventory Count/Errors

1. At the end of each shift, the licensed nursing staff will account for all controlled substance inventories.
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. All narcotics keys will be counted, recorded, and handed to the oncoming charge nurse.

7. Any nurse who leaves the facility with medication keys shall be immediately notified and return (in person) to the facility with the keys.

Controlled Substance Administration and Disposal

1. Wasting a single or partial dose, or up to 2 doses of a controlled substance:
 - a. The licensed nurse will summon another licensed nurse to co-sign the amount of the controlled substance that needs to be wasted due to accidental breakage, contamination, damage, partially used, or resident refusal.
 - b. In 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.
 - c. The licensed nurse shall not solicit the signatures on any record of a person as a witness to the wastage of a controlled substance when that person did not witness the wastage.
 - d. The wasted amount of the controlled substance will be entered and deducted from the balance on the next unused line of the narcotic use record and both nurses will sign and time the entry of the wasted medication.
 - e. If this entry does not suffice as explanation, further details should be entered on the back of the narcotic use record and dated and signed by both nurses.
2. 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 alongside if this entry, the actual amount given to the patient will be entered, and the quantity wasted will be noted per above procedure 1a. to 1e.
3. Expired controlled substance medications, discontinued controlled substance medications or greater than 2 doses of a controlled substance will be disposed of by the pharmacist, in accordance with the State Board of Pharmacy laws, rules, and regulations.
4. No licensed nurse will ever sign out and then delegate to another nurse to administer a resident's controlled substance medication or falsify nursing or CNA signatures.
5. The nurse shall act to safeguard the resident from incompetent practice.
6. The nurse shall report to the Director of Nursing Services any licensed nurse who is grossly negligent or reckless in performing nursing functions.
7. 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 Human Resource Department.

Revised 02/01, 08/14, 12/15

NARCOTIC SCHEDULE II (S2N) ORDERS

1. All Schedule II narcotic (for example, morphine, oxycodone, and fentanyl) orders must be ordered by a physician. All licensed nurses at ISVH-B (including agency nurses) may act as physician's agent in these circumstances.

2. In the event a resident is in urgent need of a Schedule II narcotic:
 - a. The licensed nurse shall contact the resident's primary physician (or on-call physician) to discuss assessment, treatment options and determine if a Schedule II narcotic is needed to treat pain.
 - b. The licensed nurse shall then write the specific physician's order.
3. Schedule II narcotic (S2N) verbal orders or telephone orders shall be written: "V.O. or T.O. Dr. _____ via licensed nurse _____" following the medication name, dose, route, frequency, and diagnoses.

6/10, Revised 7/11, 12/15

MEDICATION ERRORS / OMISSIONS

1. A Medication and Treatment Errors and Omissions report will be completed upon identification of any of the following:
 - a. wrong resident
 - b. wrong medication
 - c. wrong dose
 - d. wrong frequency
 - e. wrong route
 - f. omitted medication(s)
2. All licensed nurses will be responsible for reporting, investigating, and documenting any medication error. The nurse discovering the error is responsible for the following:
 - a. Complete the Medication and Treatment Errors and Omissions form.
 - b. Notify the physician. (If the medication error has the potential to cause the resident serious harm, then the physician shall be immediately contacted for further directives.)
 - c. Notify the RN Unit Manager
 - d. Notify resident/family/legal representative.
 - e. Implement Alert Charting/Monitoring, if applicable (Refer to Alert Charting procedure)
3. The completed report will be submitted to the unit RN Manager 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 Incident and Accident committee, then the facility's pharmacy and therapeutics committee.

Revised 10/02, 10/08, 11/09, 12/15

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.

1. The Director of Pharmacy, nursing staff, and physician are responsible for monitoring the possible interactions that may occur.
2. 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.
3. 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

1. The Pharmacy Department is responsible for reviewing each resident's drug regimen on a monthly basis to monitor for any adverse medication reactions.

The pharmacy report will be submitted to the nursing department for review and consultation with the resident's physician, when applicable.

2. Upon review by the physician, the DNS or Unit RN Manager will complete the needed changes, keep a copy of the review, and return the original form, with completed actions, to the pharmacy.

Revised 02/02, Reviewed 12/15

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Nursing Procedure Manual

MEDICATION AND TREATMENT ERRORS AND OMISSIONS ADVERSE DRUG REACTIONS

Resident's Name: _____ Room: _____
Date of Occurrence: _____ Physician Notified: _____ Supervisor Notified: _____
Family/Legal Representative notified: _____
(Notification needs to be done immediately upon the discovery of error.)

MEDICATION AND TREATMENT

Name of Nurse making error/omission: _____ Notified:

Medication (and dose) involved: _____

Describe error/omission (list med(s) involved): _____

How discovered: _____

Effect on resident: _____

Possible harmful effects: _____

CAUSE(S) OF ERROR(S) - Check all that apply:	TYPE OF ERROR – Check all that apply:
Identification of resident	Wrong Medication:
Didn't check med label with MAR	Wrong dose
Didn't check route of administration	Wrong day/time
Didn't check that resident took meds	Wrong resident
Error in Charting	Med Omitted
Incorrectly Charted	Other (explain) :
COMMUNICATION FAILURE:	
Order not transcribed correctly	
Not read correctly	
Verbal order not heard correctly	Nurse Signature:

ADVERSE DRUG REACTION

DRUG IDENTIFIED AS POSSIBLE CAUSE OF REACTION: _____

Describe adverse reaction: _____

Describe intervention: _____

Care Plan updated: _____ Drug Allergy noted on chart (if applicable) _____

Signature of person reporting adverse drug reaction: _____

(Route to Unit RN Manager)

10/10, Reviewed 12/15

MEDICATION AND SPECIMEN REFRIGERATOR TEMPERATURES

Purpose: To ensure that refrigerators used for medication and specimen storage are clean and monitored for appropriate temperature.

- A. Medication Refrigerator
 - 1. Any medication requiring refrigeration must be stored in the secured medication room – separate from any food items or specimens.
 - 2. Medications will be stored in their appropriate containers or labeled by the Pharmacist.
- B. Specimen Refrigerator
 - 1. Specimen collections requiring refrigeration must be stored in the specimen refrigerator located in the secured medication room.
 - 2. Specimens collected such as urine or blood will be stored in the appropriate specimen container – separate from any food items or medications.
- C. Specimen refrigerators will be monitored daily (NOC) shift for appropriate temperature.
- D. Medication refrigerators will be monitored every shift for appropriate temperature.
 - 1. Refrigerator temperature must be maintained between 36-46 degrees Fahrenheit for both the medication and the specimen refrigerator.
 - 2. Temperature colder than 36 degrees or warmer than 46 degrees must be reported to the RN Unit Manager.
 - 3. Refrigerator temperature (s) must be documented on separate logs for the medication and the specimen refrigerators.
 - 4. Medication refrigerator temperatures will be documented on the "Medication Refrigerator Log"
 - 5. Lab refrigerator temperatures will be documented in the "Laboratory Refrigerator Log."
 - i. Log sheet is replaced on the first of each month.
 - ii. Refrigerator log shall be routed to the RN Unit Manager after it has been completed for the month.
- E. Refrigerators shall be cleaned on a regular basis (1st of the month) by NOC shift and PRN as needed.

12/00, Revised 05/15, 02/17; Reviewed 12/15

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MEDICATION REFRIGERATOR LOG

NOTE: Vaccine must be stored at between 36 and 46 degrees (2° C & 8° C). Refrigerator temps greater than 46 degrees or less than 35 degrees must be reported to RN Unit Manager and medication moved to appropriate alternate refrigerator. Contact maintenance ASAP, contact pharmacy for further instructions on safety of medications.

Day	Temperature (Fahrenheit)						Comments & Adjustments
	Days / Initials		Eves / Initials		Nocs / Initials		
1							
2							
3							
4							
5							
6							
7							
8							
9							
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26							
27							
28							
29							
30							
31							

Unit: _____ Month/Year: _____

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LABORATORY REFRIGERATOR LOG

NOTE: Temperature should be within the range of 36-46 degrees; temperatures not within this range must be reported to the RN Unit Manager.

Unit: _____

Month/Year: _____

Day	Temperature (Fahrenheit)	Comments/Adjustments	Nurse Initials
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
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Revised 06/15, 02/17; Reviewed 12/15

STANDING ORDERS

~~When a standing order is used, a physician telephone order must be entered and the physician's electronic signature obtained.~~ (This order is to be used as a one-time order for the time frame specified, typically three (3) days.) If a resident continues to need the medication/treatment for more than the specified period, then the physician must be contacted to verify whether or not the resident needs to be evaluated further and/or the medication/treatment ordered on a regular or PRN basis.

PRIOR TO WRITING ANY STANDING ORDER, IDENTIFY RESIDENT'S ALLERGIES.

1. Analgesic/antipyresis: Call provider for new fever $\geq 100.5F$

- a. Acetaminophen tablet 325mg give 2 tablets by mouth every 4 hours as needed for minor aches/pains or temp greater than **100.5F**(oral or ear). Total acetaminophen dosage not to exceed 3000mg/24hr period.
- b. Acetaminophen suppository 650mg insert 1 suppository rectally every 4 hours as needed for minor aches/pains or temp greater than **100.5F** (oral or ear). Total acetaminophen dosage not to exceed 3000mg/24hr period.
- c. Aspirin tablet 325mg give 2 tablets by mouth every 6 hours as needed for minor aches/pains or temp greater than **100.5F** (oral or ear) if allergic or unable to take Tylenol (acetaminophen).

2. Bowel Elimination (combine with #5?)

- a. Colace (Docusate Sodium) tablet 100mg give 2 capsules by mouth in the evening.
- b. Senekot (sennoside) tablet 8.6 mg by mouth two times a day.

3. Cerumen

Debrox Solution 6.5% 2 drops in affected ear QHS as needed cerumen build-up x 4 days,
tap water
irrigation to affected ear on day #5. Notify physician or designated provider for
ear pain, discharge, or
persistent change in hearing.

4. Chest Pain: Call provider if not chronic condition.

- a. Supplemental Oxygen ~~@ 2 liters/minute per nasal cannula continually for chest pain.~~ As needed to maintain O_2 sats $\geq 90\%$.
- ~~b.~~ Nitroglycerin 0.4 mg. SL, every 5 minutes x 3 doses. Obtain blood pressure before and after each dose. Discontinue if BP is $<80/60$. ~~Call physician or designated provider for orders if chest pain not relieved after 3 doses.~~ Call EMS if 2nd dose needed if resident not "comfort care."

5. Constipation

- a. MOM 30 cc. by mouth x 1 dose with no documented bowel movement in last 48-72 hours.

- b. Dulcolax delayed release 5mg. give 2 tablets by mouth x 1 dose with no documented bowel movement following administration of MOM (within last 24 hours) or no documented bowel movement in last 48-72 hours.
 - c. Dulcolax suppository 10 mg insert 1 suppository rectally one time only with no documented bowel movement following administration of Dulcolax tabs or MOM (within last 24 hours)
 - d. Sodium phosphate enema insert 1 dose rectally one time only with no documented bowel movement following administration of bowel meds (within 24 hours).
- 6. Cough/Sore Throat/Cold/Sinus-nasal congestion**
- a. Guaifenesin syrup 10 ml. by mouth q 4 hours as needed cough x 3 days.
 - b. Halls Mentholiptus or generic equivalent cough drop 1 lozenge by mouth up to 8 per day for cough x 3 days. (Dysphagia resident?)
 - c. Cepacol or generic equivalent throat lozenge 1 lozenge by mouth q 2 hours as needed for sore throat x 3 days. (Dysphagia resident?)
 - d. Sudafed 30 mg. 1 tab by mouth q 6 hours as needed nasal congestion x 3 days - do not give if BP is greater than 160/100.
 - e. Saline nasal spray 2 sprays each nostril q 1 hour as needed for dryness/nasal congestion x 3 days.
- 7. Diarrhea: If 3 or more watery stools that are out of character for resident, call provider.**

Imodium give 2 tablets by mouth every 6 hours as needed for loose stools x 3 days if 3 or more loose stools in a 24 hour period.

8. Dyspepsia

- a. Mylanta suspension or generic equivalent antacid give 30cc by mouth every 2 hours as needed for gastric distress up to 200cc per day x 3 days.
- b. Calcium Carbonate tablet chewable 500 mg give 2 tabs by mouth q 2 hours as needed for gastric distress up to 10 tablets per day x 3 days.

9. Eye Irritation

Artificial tears (Polyvinyl Alcohol) 1.4% instill 2 drops to both eyes every 1 hour as needed for minor eye irritation/dryness x 3 days.

10. Hypoglycemia (?) look at this?

Refer to Hypoglycemia Treatment Reference Guide (write physician standing order(s) for Glucose Gel, GlucaGen, and finger stick Blood Glucose as appropriate – located in Red Binder on each med cart & Nursing Procedure Manual).

11. Immunizations/PPD

- a. Influenza vaccine 0.5 ml IM x 1 dose every fall, if no documented allergic reaction to vaccine and consent is signed.

- b. Pneumovax 23 0.5 ml IM (PPSV23/PPSV) as needed according to criteria for pneumococcal vaccine as listed in Pneumococcal Vaccine procedure and consent is signed.
- c. Prevnar 13 vaccine (PCV 13) 0.5 ml IM as needed according to criteria for pneumococcal vaccine as listed in Pneumococcal Vaccine procedure and consent is signed.
- d. PPD Mantoux skin test 5 units subdermal forearm, within 3 days of admission, read within 48-72 hours, repeat test in 7 days, read within 48-72 hours.
- e. Boostrix Tdap vaccine 0.5 ml. inject entire contents of pre-filled syringe IM per T-dap vaccine procedure and consent form is signed.

12. Nausea/Vomiting

- a. Promethazine HCL (Phenergan) 12.5 mg. IM 0.25 ml, by mouth or suppository q 6 hours as needed for nausea and/or vomiting x 48 hours.
- b. Zofran 4mg SL q 6 hours as needed for nausea and/or vomiting x 48 hours.

13. Oxygen Saturation, decreased. **Call provider.**

- a. Oxygen sat check Q shift,
- b. Oxygen at 1 l/min per NC continuously. If O2 falls below 88% LN may increase O2 up to 4 l/min (using smallest amount possible). If sats cannot be maintained at or above 88% on 4 l/min, or for resident refusals. ~~notify MD.~~

14. Compromised Perianal Skin

- a. Z-guard cream to (specified area) q shift until healed then D/C.
- b. Monitor irritated / excoriated / denuded skin located (_____) q shift until healed then D/C. Doc "Y" if no s/s of infection and pain is managed. If exceptions doc. "N", select chart code 9 'other/see progress notes and progress note findings'.

15. Post-Foley Discontinuation

Bladder scan q 6 hours and following a void (PVR) x 3 days. Straight cath if > ~~500~~ 400 cc. Notify physician if scans >~~500~~ 400 cc. continue through 3rd day.

16. Skin Tears

- a. Cleanse skin tear located _____ with normal saline approximate edges if possible, apply steri-strip now.
- b. Cover steri-strips located _____ with dry dressing and secure with tape or Kerlex. Change dressing q 72 hours and PRN on PM shift. D/C when resolved.
- ~~e.~~ All other skin/wound problems need to be referred to resident's primary physician **and communicated to RN Manager and Skin/Wound nurse** for appropriate orders ~~(and communicated to RN Manager and Skin/Would nurse).~~

17. Suspected Urinary Tract Infection

- 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)
- c. Criteria for performing a chem-10 urine dip test on residents with an indwelling urinary catheter (**any one of these**):
 1. Fever > 100.0 F 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 onset of delirium (new confusion or hallucinations above baseline mental state)
- d. ~~Notify~~ **Call** 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.

18. Suspected Narcotic Over-Sedation

~~Notify~~ **Call** resident's primary physician of resident's signs and symptoms **immediately**. If an order for Narcan (naloxone) is obtained, ALSO obtain an order for transfer of resident to ER for evaluation.

19. Expected Death Notification

When a resident who is expected to die expires and it is within normal business working hours, notify physician at time of death. When a resident who is expected to die expires

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during non- working business hours, write order to release the body to the mortuary of choice and notify the physician **via secure message**.

Revised 7/02, 2/03, 7/04, 3/05, 4/06, 5/06, 11/06, 08/07, 07/08, 08/07, 11/09, 6/10; 2/11, 9/11, 12/11, 1/12, 06/12, 09/12, 11/12, 01/13, 09/13, 03/14, 11/14, 12/14, 10/15, 11/15, 04/16, 05/16, 02/18, 03/18

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SALINE LOCK MAINTENANCE PROCEDURE

1. The saline lock will be maintained by an RN or an IV certified LPN.
2. Saline flush shall be done at least every eight hours or q shift.
3. Cap will be changed with site rotation every 72 hours and PRN as required.
4. The following procedure shall be utilized when flushing an IV saline lock.
 - a. Flush catheter with 5 cc normal saline before administering medications.
 - b. Administer medications (if applicable).
 - c. Flush catheter with 5 cc normal saline following administering medications.

07/02, updated 12/11

IV FLUID ADMINISTRATION

Intravenous fluids used for hydration 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.

Intravenous fluids/medications equal to or less than 100 ml. per order (e.g. antibiotics) may be administered without the use of an IV pump, however, should be infused at a rate considered acceptable by pharmacy/drug standards.

Labeling

1. All IV medications will be labeled with:
 - a. Name, address and phone number of dispensing pharmacy
 - b. Full name of resident
 - c. Name of prescriber/physician
 - d. Dispense date.
 - e. Prescription number
 - f. Name and concentration of medication
 - g. Name and concentration of primary solution
 - h. Volume dispensed
 - i. Directions for use including frequency, rate, and duration of administration.
 - j. Storage requirements
 - k. Expiration date.
 - l. Pharmacist's initials.
2. All IV fluids and tubing will be labeled with:
3. Any additives (e.g. potassium) to the fluids
4. Date and time put into use
5. 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.

07/02

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 as well as the potential complications involved in giving medication via this route.
4. RNs should assess and recommend other routes of administration if available.
5. A resident's drug allergies must be evaluated before administration.
6. The resident will be monitored closely through the infusion. The medication will be terminated immediately if any untoward reaction occurs.

07/02

IV SITE ASSESSMENT

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 q shift on the eMAR/eTAR.

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.

Revised 04/09, 11/14

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.

Lines that typically require the injection cap to be changed are long-standing such as PICC, central and subclavian lines.

Supplies:

1. 2 – sterile injection caps
2. 2 – Betadine swabs
3. 2 – alcohol wipes
4. 2 – syringes
5. Normal saline

Procedure:

1. Perform hand hygiene thoroughly.
2. Put on clean or sterile gloves.
3. Prepare injection caps according to the instructions.
4. Pre-fill the injection caps with normal saline.
5. Unscrew one of the old injection caps and discard, holding the catheter adapter below the level of the heart.
6. Using Betadine swab, followed by alcohol wipe, clean around the hub where the injection cap was connected to the catheter. (Make sure to not touch the inside of the catheter.) Allow to air dry.
7. 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.
8. Repeat the process for the second cap.
9. Document interventions on eMAR or eTAR sheet, as appropriate.

08/04, 11/14, 08/17

PERIPHERAL IV CATHETER / INSERTION

1. RNs and IV certified LPNs 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 (TSM) 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

CATHETER CARE CHART

Type of Catheter	Groshong Nxt	Power PICC	Peripheral Line
Frequency of Flush Do not flush against resistance – a clot may have formed.	Q Shift (min.) and/or Before and After Use	Q 12 hours (min.) and/or Before and After Use	Q Shift (min.) and/or Before and After Use
Type of Flush: NS = Normal sterile saline	10 cc NS ONLY 10 cc. NS after blood draw	Unused port(s): Flush with 5 cc H (100U/cc).	5 cc NS
H = Heparinized NSS		Used port(s):	
Flush ALL ports		<u>Before use</u> flush with 10cc NS	
Flushes for Groshong Nxt or Power PICC shall be done with a 10-12 cc syringe		<u>After use</u> flush with 10NS followed by 5cc H (100u/cc)	
Dressing change frequency	Q 72 Hours or Q 7 days if BIOPATCH used	Q 72 Hours or Q 7 days if BIOPATCH used	Q 72 hours
Injection port frequency of change	With dressing change or after blood draw	Q 7 days, or with dressing change, or after blood draw;	Q 72 hours
		or when cap has been removed for any reason	
Site rotation change frequency	Remains in place for duration of therapy as ordered by physician		Q 72 hours or PRN

Updated 12/11

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.

The following procedure will be utilized:

1. Clamp IV tubing if resident has continuous infusion.
2. Stabilize catheter by pressing on it with one hand while gently stretching and peeling transparent dressing with the other. Remove dressing.
3. Inspect site for complications.
4. Gently remove IV device from the vein.
5. 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.
6. Document removal including:
 - a. Date and time.
 - b. Site assessment and location.
 - c. Condition of catheter upon removal.
 - d. Reason for removal of catheter.

7/02

PICC / MIDLINE / CENTRAL LINE DRESSING CHANGE

1. Dressings are to be changed using sterile technique.
2. Only RNs and IV certified LPNs will change dressing.
3. Transparent semipermeable membrane (TSM) dressings are to be changed every 72 hours, unless the BIOPATCH is utilized. This includes any gauze and tape dressing or gauze and TSM dressing.

If BIOPATCH is utilized, then the dressings are to be changed every 7 days. Dressing is to be changed immediately if it becomes wet, soiled, or loses its occlusive seal.

4. Extreme care must be taken not to dislodge the catheter. Catheter length can be measured with dressing change and if it increases greater than 2”, notify the physician. (The concern is a malposition of the catheter tip.)
5. Catheters will utilize a heparin Luer-Lok device to maintain a closed system.

Dressing Change Procedure

1. Gather equipment; BIOPATCH, dressing change kit, gloves, etc.
2. Perform hand hygiene.
3. Explain procedure to resident.
4. Put on clean gloves.
5. Remove existing dressing – while stabilizing catheter, using one hand, gently loosen dressing and lift away from skin with the other hand.
6. Inspect the site for any swelling, redness, or drainage. If any of these are present, the physician should be notified.
7. Remove gloves. Open dressing kit to create sterile field
8. Put on sterile gloves.
9. Using an alcohol swab stick thoroughly cleanse the area working from the catheter exit site outward, moving in a circular motion and extending the cleansed area to a diameter of 3-4 inches. Repeat, using remaining two swab sticks making sure sutures are clean and intact, if present.
10. Cleanse the area in the same manner as above using three Providone iodine swab sticks. Care must be taken not to pull on the catheter. Allow to air dry for at least 30-60 seconds – do not blow or fan.
11. (If using BIOPATCH continue with the following steps, if not using BIOPATCH proceed to step 15.)
12. Remove BIOPATCH from the sterile package using aseptic technique.
13. Place BIOPATCH around catheter, making sure the blue print side is facing upwards.
14. Place BIOPATCH around the catheter site so that the catheter rests upon the slit portion of the BIOPATCH. The edges of the slit must be pushed together and remain in contact.

15. Secure the catheter (and BIOPATCH if used) to the skin with a transparent film dressing, centering dressing over catheter exit site. Note: If a gauze dressing is used make sure gauze is never allowed to lie under catheter. If this occurs, the catheter becomes “sandwiched” between the gauze and dressing and when the dressing is removed; the catheter is at risk of being torn out.
16. Place tape or steri-strip (adhesive side up), under the catheter extension area, crossing over the extension and on top of the transparent dressing.
17. Tape all connections.
18. Label dressing with the date, time and nurse’s initials.
19. Dispose of used equipment properly.
20. Perform hand hygiene.
21. Document procedure and site assessment
22. Dressing Changes should occur at a minimum of every 7 days and as needed if saturated with exudate, soiled or loses its occlusive seal.
23. To remove the transparent film dressing, pick up the corner of the dressing and stretch the dressing away from the catheter holding the catheter in place. Stretch and peel until dressing with the attached BIOPATCH is removed.

7/02, revised 04/06, 8/11

PICC/MIDLINE/CENTRAL LINE REMOVAL

A physician order is required to remove a PICC Line. (Midline catheters being a peripheral catheter are removed when there is evidence of peripheral complications or at the end of infusion therapy. A PICC Line or Midline catheter can be removed by a registered nurse.

Supplies:

- Sterile 4 x 4
 - Gloves
 - Suture removal kit
 - Antibiotic Ointment
 - Transparent Occlusive Dressing
1. Review patient's chart for any contraindications to removing the patient's PICC or Midline catheter.
 2. Obtain physician order for PICC Line removal only.
 3. Explain procedure to patient. Instruct patient to turn head away from catheter and to not talk during the procedure.
 4. Place patient in Trendelenburg's position, if contraindicated use reclining position or supine position.
 5. Perform hand hygiene.
 6. Put on non-sterile exam gloves.
 7. Remove old dressing and discard and remove gloves, follow steps 1-5 on the PICC/MIDLINE/CENTRAL LINE DRESSING CHANGE Procedure.
 8. Perform hand hygiene.
 9. Put new pair non-sterile exam gloves.
 10. Remove sutures, if present using sterile forceps and scissors
 11. Assess site, if site has signs and symptoms of infection notify MD.
 12. Removing catheter:
 - a. Have patient perform Valsalva's maneuver. If Valsalva maneuver is contraindicated or patient is unable to perform, withdraw catheter during patient exhalation.
 - b. While applying pressure to the site with sterile 4x4 gauze, slowly withdraw the catheter from the vein. If resistance is encountered when the catheter is being removed, the catheter should not be forcibly removed, stop and notify MD.
 13. Inspect removed catheter carefully for intactness.
 - a. If damaged notify MD and apply direct pressure over the site. If catheter fragment is palpable, apply additional pressure distal to the catheter fragment to prevent migration.
 14. If removed catheter is intact, then apply pressure to the catheter removal site until bleeding is controlled, at least five minutes, maybe longer then,

15. Apply antibiotic ointment and sterile occlusive dressing. Site should remain covered until epithelialization occurs. Change dressing every 24 hours.
16. Document patient education, date and time of removal of catheter, assessment of site, ease of catheter removal, length of time pressure applied to achieve hemostasis, application of dressing, and patient tolerance.
17. Obtain order for venipuncture site dressing change and monitor per facility procedure.
18. Initiate Alert Charting for this resident for no less than 24 hours.

8/11