

IDAHO STATE VETERANS HOME – LEWISTON
NURSING PROCEDURE MANUAL

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I ADMINISTRATIVE

ALERT CHARTING

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

1. The following procedure will be implemented when one or more of the following resident situation/conditions occurs:
 - a) New medication(s) ordered.
 - b) Increase/decrease in existing medication orders.
 - c) Acute illness.
 - d) Fall-with or without injury. .
 - e) Incident (of a significant nature, e.g., resident to resident altercation).
 - f) New medical diagnosis identified.
 - g) Change in condition identified such as functional status, weight loss, cognitive/behavior, LOC, etc.
 - h) New admits and residents re-admitted.
2. Staff members responsible for implementing Alert Charting procedure (per above identified items) is as follows:
 - a) Licensed nurse noting order(s).
 - b) Licensed nurse completing Incident Report.
3. Staff members responsible for implementing Alert Charting will enter the resident's name in the Alert charting book located at the Nurses' station. Items to be completed include:
 - a) Start date.
 - b) Reason/Problem (e.g. Antibiotic-Keflex-URI)
 - 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.)
 - i. Charting shall be done q shift by the licensed staff assigned to the resident, according to the documentation items required. In the case of alert charting

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pertaining to skin issues, a specific shift will be designated to assess and document.

- ii. Condition requiring antibiotic usage will be initiated upon resident assessment including resident condition, overall assessment (i.e.: lung sounds, sputum, color, color of urine, pain with urination et.) reason for ABO, vital signs. Any resident on an ABO will be assessed Q shift and charted in resident medical record for length of time of ABO. If s/sx of which the resident was experiencing while on treatment do not dissipate within the length of time mentioned, nursing assessment and documentation will continue until condition has cleared.
- iii. New medication orders increase/decrease in existing physician orders, the resident will be assessed, and nursing assessment will be documented in the medical record Q day for 72 hours. This will be primarily assigned to the AM shift.
- iv. Falls will be charted on Q shift for 72 hours, this includes falls with an injury.
- v. All other incidents (excluding - bruises and skin tears) involving residents as mentioned above will be assessed and documented Q shift for 72 hours.
- vi. Admission charting will include date of admit, time of admit, how transported, if accompanied by family, oriented to room, call light etc. New admit charting will be done Q shift for 7 days.

Revised 07/19

CALL-IN PROCEDURE

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

1. It is expected that you, personally, notify the facility of your absence at least two (2) hours prior to the beginning of your scheduled shift. (Calls from family members, etc., will not be accepted unless the employee is incapacitated.) It is not acceptable for the employee to leave a voice mail, you must talk with the RN Manager, DNS or the RN on duty.
2. The RN Manager, DNS or LN taking a call from an employee who will be ill and unable to report to work as scheduled can request a physician's excuse from the employee.
3. When a call-in is received, the person taking the call will document the information on the Absentee form. The RNM, DNS or Licensed Nurse will ask the employee what is wrong and will be expected to document on the Absentee form the reason for absence. The LN will then document on the nursing schedule and attempt to cover the shift. Every effort will be made to maintain nursing PPD above 2.5. (To calculate the PPD – LNs + CNAs hours divided by the census in a 24-hour period) If a LN calls in every effort is to be made to replace that person. If unable to replace staff and the minimum is not met the RNM and/or DNS are to be notified to help problem solve.
4. The Staff Absentee form will be routed to the RN Manager and/or the designee who will then document on the employee absentee record.
5. In the case of an employee not showing up for work (no call or no show) the Licensed nurse on duty will try to make contact with the employee to determine the reason for the employee not reporting to work as scheduled. If unable to contact the employee the procedure is the same as above. If this occurs the Licensed nurse will report this to the RNM or DNS who will then make every effort to contact the employee. It is the responsibility of the RNM or DNS to determine if this is an excused absence or unexcused absence.

Revised 07/19

LABORATORY TEST RESULTS NOTIFICATION

Purpose

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

Procedure

Critical Lab Values:

1. The laboratory contract provider will call the facility with any critical lab values.
2. Upon receipt of information regarding critical lab values, the LN will immediately contact the resident's physician/medical provider for further instructions/orders. A nursing note will be written in the progress note by the LN notifying the physician. The note should address the lab test, and if applicable, the current dosage of any relevant medication (e.g. coumadin)

Abnormal Lab Values:

1. Upon receipt of the hard copy of abnormal labs, the licensed nurse will review, initial as reviewed. The note must address the items stated above. LN will identify urgency of communicating with the physician based on MD request, seriousness of the abnormality and individuals' current condition.

Normal Lab Values:

1. Upon receipt of the hard copy revealing normal lab values, the LN will review, initial as reviewed and then place the copy to be reviewed by MD in the box at the nurse's station. If the resident's primary physician is not due to make rounds, then the lab results will be faxed to the physician. The LN will indicate this on the lab hard copy.
2. After appropriate reviews and signatures, the hard copy will be scanned into the resident's medical record.

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LIGHT DUTY-NURSING STAFF

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

Reviewed 07/19

LIGHT DUTY JOB DESCRIPTION

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

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

Employee Name: _____

This employee is able to perform the light duty job description as outlined above.

Reviewed 07/19

MOTION DETECTION ALARMS

Purpose:

To ensure motion detection 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 alarms are available as the needs arise.
2. Each alarm device shall have a regularly scheduled plan to replace batteries.
 - a) The Storekeeper shall be responsible for replacing alarm batteries.
 - b) The Storekeeper shall maintain a list of each resident's device.
3. Each pressure pad is clearly marked with the date put into use and the date of anticipated expiration (in accordance with the manufacturer's guidelines). The storekeeper shall be responsible for the retrieval of discontinued alarms.

Revised 07/19

NURSING CLOTHING AND UNIFORM PROCEDURE

Professional Attire in the Workplace

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

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

Uniform components for nursing staff are:

- Solid or print scrub tops worn with uniform style slacks that are in good repair.
- Inappropriate slacks include jeans, sweat pants, leggings, flannel pants, spandex or form fitting pants such as would be appropriate for biking or recreational activities.
- Exposure of body parts such as the abdomen, torso or chest due to low cut shirts or pants is not appropriate. Tank tops and/or sleeveless tops are prohibited unless worn with a lab coat. In the summer months capris may be worn but must be uniform or casual dressy style and worn below the knee.

Shoes:

- Shoes should be comfortable, clean and in good repair.
- Open toe shoes are prohibited for safety reasons.
- Shoes will be low heeled and have non- skid soles.

Grooming:

- Finger nails should be kept short, clean, neatly manicured.
- Hair is to be clean, well-groomed and worn in such a manner that it will not interfere with resident care and will present a professional image.
- Facial hair must be trimmed and kept clean.
- Hats are not allowed.
- Earrings should be worn in a professional manner. No earrings that are dangling below the ear lobe.
- Piercings limited to small studs. All others should be approved by the administrator prior to wearing on the floor. Decisions will be based on safety and infection control considerations.
- There will be a limited amount of ring/hand jewelry. Jewelry worn on hands will not have any sharp edges that could cause scratches etc. to residents when giving care.

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Perfume/Cologne:

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

Identifying Nametag:

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

Casual Clothing:

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

Activity Day Clothing:

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

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

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OVERTIME

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

Hands-on caregivers receive overtime at 1.5 times the hourly rate. LN's receive overtime pay at 1.5 times the hourly rate which may be paid for or compensatory time accrued. RNs may receive overtime at 1.5 times hourly rate or may choose that time as compensatory time.

The DNS accrues compensatory time at a rate of 1.5 times the hourly rate.

If in-service time takes the employee over forty hours in a one-week time period, he/she will receive 1.5 times the hourly rate which may be paid for or compensatory time accrued.

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QUALITY ASSURANCE PROGRAM

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 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 improving 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 Americas Heroes.

The 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 (at a minimum) and more often as deemed necessary by the IDT, depending on facility need.
2. The committee shall consist of the Director of Nursing Services, Administrator, Medical Director, Pharmacist and a minimum of three other staff members.
3. All committee members will be expected to attend each meeting regardless of their reporting responsibility.
4. The DNS (or designee) is chairperson.
5. The Chairperson will accept or assign responsibility for taking/transcribing the minutes of the meetings and for maintaining committee minutes, reports, schedules and other pertinent data.

Quality Assessment

6. Quality Assurance items to be monitored will be established by the committee, interested parties, needs of the facility/residents and in accordance with pending and subsequent VA and L&C surveys/findings.
7. Typically, the facility will regularly review and trend items such as incident/accidents, resident-to-resident altercations, medication errors, adverse drug reactions, sentinel events and infection control rates.

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8. A threshold percent may be established for each of the Quality Assurance items. Percentages less than threshold or more than the national standard shall have a plan of action to address corrective actions/interventions planned.
9. In addition to the above, facility staff or other interested parties may ask the Committee to evaluate other concerns within the facility.

Quality Indicators

10. The RAI -24 QI indicators will be reviewed in the QA Committee.
11. The Director of Nursing Services (or designee) is responsible for obtaining the facility's QI profile, reviewing each of the areas and developing plans of action for each item above the 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 QI monitor that is above the 75th percentile rank, those items which are "flagged" or identified as a sentinel event.
3. The plans of action shall include the specific problem, the planned intervention, person(s) responsible for the interventions, evidence of improvement, and the target date of completion.
4. Monitor(s) not in compliance shall be reviewed each meeting with action plans revised as appropriate and until resolved.
5. The committee members are responsible for providing input into the development of the plans of action.

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PHYSICIAN RECAPS/ORDER REVIEWS

Purpose:

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

Procedure:

1. The Pharmacist will review each resident's drug regime monthly. These reviews will be documented in the resident's electronic medical record and to include the pharmacist's comments and recommendations.
2. The Pharmacist's comments and recommendations will be reviewed by the DON, RN Manager, and/or designee and all recommendations will be referred to MD for review.
3. DON and RN Manager or designee, will also review all residents' orders monthly in conjunction with the pharmacy review.
4. Resident order reviews will be signed monthly by the physician in the resident's medical records.
5. Residents whose primary physician is not able to sign orders in the electronic medical record will have the pharmacist's recommendations and orders sent to them for review. These reviews will then be scanned into the resident's medical record.

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Resident Name: _____ **Med Rec #:** _____

Pharmacy Review:

1. Comments:

2. Recommendations:

I have reviewed the facility's monthly physician orders and the residents medical record.

Pharmacist Signature: _____ Date: _____

Physician Review, Response to Pharmacy Recommendations and Comments:

I have reviewed the facility's monthly physician orders and the pharmacy review. I certify that these physician orders are current for 45 days.

Physician Signature _____ Date: _____

Nurse Review: _____ Date: _____

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 will page the resident, 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 communicate with Administrative Supervisors during the next 5 minutes. In the meantime, institute the following steps:
 - 1) Make sure the resident is not on an activity or signed or signed out of the facility.
 - 2) Call other nursing personnel on that shift. Describe who is missing.
 - 3) Send the caregiver on the wing who has a resident missing, to look in all hallways and common areas: Dining Room, Lobby/Canteen, Library/Activity Room, all living room areas on other wings.
 - 4) Send a caregiver to walk around the perimeter of the Veterans home. If dark, a second caregiver may be sent as well. Walkie – Talkies are to be sent with anyone exiting the building to look for the resident.
4. If after 30 minutes have elapsed, and all efforts have failed, notify DNS or nursing manager. If neither available the RN in charge will notify the police.

At this time the family will be notified. The RN in charge will at this time notify the Administrator, DNS, RNM and SS.

Continue to individualize search drill according to resident's care plan. Continue search until information is received, or resident is located.

Remember, safety is always our major concern.

Once resident is located, RN in charge will develop an incident report containing the following data:

- 1) Time elopement occurred (or time first noted when resident was missing).
- 2) Steps initiated and time when completed.
- 3) Activity from where elopement occurred.
 - a) Going to/from meals.
 - b) From Activity
 - c) From Wing
- 4) Plan of prevention indicating where safety breakdown occurred.

Social Services will notify the Bureau of Facility Standards reporting portal in accordance with reporting protocol.

Revised 07/19

WANDER GUARD MONITOR PROTOCOL

The Wander Guard System has been installed on seven (7) doors at the 1SVH-L. These doors are:

1. Main Entrance
2. Canteen
3. West Exit door
4. East Exit door
5. Activity room door
6. North doors
7. South doors

If a resident has a transistor bracelet on and approaches one of these doors, once the door is opened the alarm will sound.

There is an annunciator panel in the facility; this is located at the nurse's station. The panel will signify which door is sounding the alarm. The alarm can only be reset at the door, and the code is **1234#**.

Reviewed 07/19

VISITING HOURS FOR THE NURSING WING

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

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

Members of the clergy are admitted at any time.

When a resident is critically ill or terminal, family members will be accommodated as requested. If possible, the Butterfly room will be provided at this time for the privacy of residents and family. If the Butterfly room is not available, a private room may be offered.

Revised 07/19

RESIDENT TRUST PETTY CASH - NURSING STATION

To meet Federal Medicaid rules for access to Resident Petty Cash funds, a separate petty cash fund will be maintained at the Nursing Station 24 hours a day, seven (7) days a week. The Resident Trust Petty Cash Fund —Nursing Station will be maintained at \$100.00. The custodian will be the designated Director of Nursing Services.

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

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

The petty cash funds will be secured in the locked drawer at the nurse's station. At the beginning and end of each shift, the charge nurse will count and sign off to the on-coming charge nurse all available funds. The petty cash has to reconcile with receipts and cash remaining. In the event that the petty cash does not balance, the charge nurse is responsible for unaccounted funds.

If a resident wishes to withdraw money from resident trust petty cash after hours the charge nurse will document on a withdrawal slip showing the date, name of resident, withdrawal amount and resident/staff signatures.

The Charge Nurse or designee will turn in any withdrawal or deposits the next business day for posting to the resident's accounts.

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

Reviewed 07/19

NURSING DAILY STAFF POSTING

There is a requirement that nursing post daily staffing. It is to be displayed at the nurse's station at all times. The RN Charge for each shift is responsible for completing that shifts section.

The night shift RN will place a new sheet each AM and will record the oncoming shift Census and employees' numbers.

Each shift the LN assigned to the West wing will record the number of RN's, LPN's and CNA's. The LN will record the total hours worked for each discipline. Example 2 RN's would equal 16 hours worked etc.

Only direct care staff are counted. This does not include the MDS nurse, DNS, RNM, Rehab CNA's and Transportation CNA.

Reviewed 07/19

DINING ROOM PROCEDURE

Dining Room Procedures:

1. The LN on the West wing will supervise the Main Dining room.
2. One CNA will be assigned to stay on the floor to answer lights etc. while all other CNA's report to the dining rooms at or before the start of each meal.
3. If the resident prefers a shirt protector then assist resident with donning the shirt protector.
4. Wash hands prior to passing food trays. Set up all trays, cut meat, pour coffee or other liquid, salt, pepper, etc. **NO FOOD IS TO BE TOUCHED BY STAFF.**
5. Warm wash clothes are to be offered to all residents before and after each meal.
6. After helping residents with their meal, assist with washing of their face, hands and wheelchairs of all residents as they leave the dining room.
7. Nursing staff will circulate the dining room during each meal to encourage residents to drink their fluids. Any resident(s) who eats less than 50% of their meal will be offered an alternate. Percentage (%) of alternate eaten **MUST** be charted in the medical record or if offered and refused R for refused will be charted. The RN on staff is responsible for assigning a nursing staff member to chart meals in the medical record.
8. All spills must be cleaned up immediately by whoever sees them first. They are very dangerous to both residents and staff.
9. NO staff are to break during meal times.

DINING ROOM PROCEDURE FOR NORTH WING DINING

1. The meal times are posted as 0715, 1215, and at 1715. The LN assigned to the North wing will oversee this dining room. The LN will assist the CNAs at meal times. After the meal is complete the LN will ensure that the % and fluids received and taken are recorded. The LN will ensure the kitchen cart returns to the kitchen.

Revised 07/19

RESIDENT PERSONAL FURNITURE PROCEDURES

Purpose:

To assure that all outside furniture (chairs and recliners) and electrical devices (fan, VCR, etc.) meets the safety and/or UL requirements as well as infection control policy.

Procedure:

1. The furniture (chairs and recliners) must be in good repair of non-permeable material to meet Infection control guidelines.
2. Electric devices (fan, VCR, etc.) must have the appropriate URL rating.
3. The furniture and/or electrical devices will be taken to the resident's room and floor staff should document the items on the Inventory List.
4. An entry should be made on the Maintenance log for them to inspect the item. Entry shall indicate what it is, for which resident and in which room.
5. Maintenance will inspect the furniture and/or electrical devices and if approved, they will place a tag on the equipment indicating approval. If not approved, Maintenance will notify Administration, Social Services or DNS to speak with the resident and/or family about removing the item from the facility.

Revised 07/19

RESIDENT LAUNDRY – DONE BY FAMILY

Purpose:

To ensure residents personal laundry needs are met when the family requests to perform the laundry duties for their loved ones.

Procedure:

1. When nursing staff are informed that a family members wishes to take care of the resident's personal laundry themselves, notify the family member that they must provide a hamper with a closed lid for their loved ones. Also, notify them that the laundry must be done at least weekly.
2. Notify Housekeeping that the family member wishes to do their residents laundry and obtain a sign from them stating, "Family responsible for resident's laundry".
3. Hang sign in resident's room in laundry area.
4. Notify Charge nurse to ensure the information is passed to the needed entities.

Reviewed 07/19

SMOKING AND BREAK REGULATIONS

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

Revised 07/19

PERSONAL GIFTS OR GRATUITIES

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

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

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

Reviewed 07/19

MOTORIZED WHEELCHAIR/SCOOTER PROTOCOL

Purpose:

To provide those residents (whose physical limitations impede their ability to ambulate and/or propel self independently in a wheelchair) the privilege of operating a motorized wheelchair while residing at ISVH-L, without compromising the safety of the resident or others.

Protocol:

ISVH-L will support the use of motorized wheelchairs/scooters for those residents whose physical limitations of mobility impedes their quality of life and who qualify by meeting the physical/cognitive/safety standards set forth by ISVH-L and its interdisciplinary team.

Motorized Wheelchair/Scooter Standards:

1. The resident will be assessed by the facility's Occupational therapist for the cognitive and physical abilities needed to safely maneuver a motorized wheelchair within the confines of the facility and the facility grounds.
2. The resident will be re-assessed as needed to assure that he/she continues to meet the standards for physical/cognitive/safety standards.
3. The resident is responsible for obtaining (purchasing) and maintaining the motorized wheelchair/scooter in good working repair.
4. The motorized wheelchair/scooter agreement will be reviewed with the resident and/or an authorized representative who acknowledges and accepts their responsibility to abide by the agreement while he/she is a resident at ISVH-L.

Revised 07/19

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ACRONYMS USED AT THE IDAHO STATE VETERANS HOME-LEWISTON

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

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GI Gastrointestinal
GTTS Drops

HR Hour
HS Hour of Sleep
HT Height

JMA Joint Mobility Assessment

IDDM Insulin Dependent Diabetes Mellitus
IDT Interdisciplinary Team
I&O Intake and Output
IM Intramuscularly
IV Intravenously

LPN Licensed Practical Nurse

MD Medical Doctor or Medical Director depending on the context
MDS Minimum Data Set
MI Myocardial infarction
MVI Multivitamin
MVA Motor Vehicle Accident

N/G Naso/Gastric
NKDA No Known Drug Allergies
NN Nurses Notes
NO New Order
NP Nurse Practitioner
NPO Nothing by Mouth

OD Right Eye
OS Left Eye
OU Both Eyes
OOB Out of Bed
OOF Out of Facility
OT Occupational Therapy or Occupational Therapist, depending on context

P Pulse
p After
PA Physician Assistant
PC After Meals
PERL Pupils Equal & Reactive to Light
PERLA Pupils Equal & Reactive to Light and Accommodation
PM Afternoon & Before Midnight
PO By Mouth
PPD Purified Protein Derivative

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

Revised 07/19

CRIMINAL HISTORY CHECKS

Purpose:

To ensure the health and safety of the Division's residents, clients, employees, contractors, interns, volunteers, and visitors.

Procedure:

All employees, contractor employees and interns will have criminal history checks prior to providing any services to the residents of the Idaho State Veterans Home – Lewiston. Such checks and guidelines are outlined in the "Idaho Division of Veterans Services Criminal History and Background Check Procedures" HR-PR-03-02.g and are in accordance with IDAPA policy 16.05.06.

All contract employees must be approved by the Charge Nurse or RN on duty prior to providing services to any resident. The following steps must be taken each time a contract employee comes into the Home to provide services.

- 1) Contract employee checks in at the front desk with the RN on duty.
- 2) RN on duty to verify their proof of identity and/or credentials, i.e. Picture ID, picture name badge, etc.
- 3) RN on duty to verify that the Contract employee is on the approved list and has been released to work in our facility. If they are approved to provide services, have the Contract employee sign in on the Service Log. If they are not on the approved list, they will not be allowed to provide services to the resident and must leave the facility.
- 4) If Contract employee is not on list, RN on duty will provide them with a business card with information for the Criminal History Check Documentation Coordinator (Shannon Anderson, AAI).

Reviewed 07/19

SUICIDE PREVENTION

Purpose:

The Division of Veterans Services is committed to promoting the health and safety of its residents, employees and any other person in the workplace. Consequently, this suicide prevention and reporting policy is intended to raise awareness and provide guidance to employees, supervisors, and managers in carrying out an appropriate response to suicidal behavior in the workplace.

Procedure:

Refer to Suicide Prevention Policy and Procedure (IDVS-PO-17-02) from the office of the Deputy Administrator 2017.

Reviewed 07/19

USE & STORAGE OF OUTSIDE FOODS

Purpose:

To assure safe and sanitary storage, handling and consumption of foods brought into the facility by residents, their families and visitors. In compliance with CMS 480.60 (i)3 – F813.

Policy Statement:

The facility provides safe and sanitary storage and handling of foods brought in from the outside by family and visitors, and ensures staff assist residents to access and consume these foods.

Procedure:

- A. Upon admission, residents and families will be given a copy of this policy and offered a handout on safe food handling practices. (See attached)
- B. Food brought in from the outside will be checked by a member of the food and nutrition department or a licensed nursing staff to perform the following steps:
 - 1) Ensure foods brought in are not in conflict with the residents prescribed diet. If they are in conflict, the resident will be counseled on the risks/benefits and complications of eating the food item.
 - 2) Food item(s) will be labeled with the resident name, content, the date it was prepared, if known, and a discard/use by date.
 - 3) Foods brought in for a potluck event will be inspected by a licensed nurse or food service personnel and either served immediately or labeled/dated and immediately refrigerated in designated spaces. If the food item is an item to be served hot, reheat to >165°F (one time only) in the facility designated microwave oven, just prior to service.
 - 4) All foods brought in by Visitors will be clearly designated as such during service to the residents and others.
 - 5) At the discretion of the staff, any suspicious or obviously contaminated food will be discarded after verbally notifying the resident or responsible party.
- C. Non-perishable foods, specifically foods not requiring refrigeration, with the exception of fresh fruits with their peels intact, will be stored in an airtight container or Ziploc bag to prevent staleness and pest infestation. The container will be labeled with the resident's name, content and date. The container will be labeled with the resident's name, content and date. may be stored in the resident room or in the designated food storage space on each nursing unit.
- D. Residents' perishable food will be kept in refrigeration units separate from the main facility kitchen food storage.

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- E. All refrigeration units will have internal thermometers to monitor for safe food temperatures, in accordance with State and Federal standards. Designated staff will monitor and document unit refrigerator temperatures daily.
- F. Food or beverages brought in to the residents from the outside are not comingled with the main facility kitchen storage.
- G. Separate food storage and preparation areas (including a microwave oven) are designated for use for food brought in from outside sources.
- H. Temperature monitoring, disposal of outdated food and cleaning procedures for these areas will follow facility food safety and sanitation practices and the tasks will be completed by the Dietary Department.
- I. Safe and Sanitary microwave oven and food thermometer use will be posted in each area where food from the outside will be stored or prepared.
- J. Facility nursing or food service staff members will help the resident or resident family member to access, safely reheat (if necessary) and consume the foods brought in by family and visitors.
- K. If resident, family or visitor has questions about safe food handling or the storage, handling or consumption of foods brought into the facility, they should contact the Dietary Manager, Director of Nurses or the RN in charge.

Reviewed 07/19

USE OF MICROWAVE OVENS & FOOD THERMOMETERS ON NURSING UNITS

Purpose:

To assure safe and sanitary storage, handling and reheating of foods brought into the facility by residents, their families and visitors. All handlers should review the Use and Storage of Foods brought to Residents by Family and Visitors as well as the Safe Food Handling Guidelines.

Procedure:

- Dietary will be responsible to reheat/heat resident's food brought in as requested during open hours, 5 am to 7:30 pm. Nursing will be responsible to reheat/heat resident's food brought in as requested during off hours, 7:30 pm to 5 am.
- Fast foods such as burgers, chicken sandwiches and other sandwich type foods are not recommended for reheating due to microwave heating process affects quality of food and may be unsuitable for consumption.
- Clean and sanitize the microwave oven before each use with food safe (disposable) sanitizing cloth.
- Place food to be heated in a microwave safe dish and lightly cover it to avoid splattering during heating.
- Heat food to appropriate temperatures following Safe Food Handling guidelines.
 - >165 degrees F for 15 seconds to ensure pathogenic bacteria is killed in all foods, including leftovers.
 - Stir food items during microwave heating to ensure even heat distribution.
- Use a sanitized thermometer (using a sanitizer wipe/swab safe for food service) to check for safe temperatures prior to service.
- Clean and sanitize the microwave oven and food thermometer after each use.
- Dietary Services department will ensure proper calibration of food thermometer at least monthly or as needed.
- Store sanitized thermometer in designated location.
- Supervise and assist resident at risks for burns or who may need help to eat (as their care plan directs) to maintain their safety and dignity.

Reviewed 07/19

SAFE FOOD HANDLING

SAFE FOOD HANDLING

This handout may be distributed to residents, family members and visitors along with the facility policy on food brought in from the outside.

BE CLEAN, BE HEALTHY

- Wash hands for 20 seconds with soap and water before, during and after preparing food and before eating.
- Do not touch food if you are ill and do not touch ready to eat foods with bare hands.
- Wash utensils, cutting boards and countertops with hot, soapy water.
- Scrub fresh fruits and vegetables under running water before eating.
- Label and date all foods being brought into the facility from the outside with name, content, date of preparation.

DON'T CROSS CONTAMINATE

- Use separate cutting boards and plates for raw meat, poultry and seafood.
- Keep raw meats, fish, and eggs separate from ready to eat foods in the refrigerator.

COOK IT

- Food brought in from outside sources be heated by facility staff member.
- Use a food thermometer to ensure food is heated to a safe temperature.
- If a facility designated microwave oven is used to cook/reheat foods, loosely cover and stir often to heat evenly.
- Cook foods to:
 - A. 165 degrees for 15 seconds – LEFTOVERS (Leftover foods may only be reheated once before discarding).
 - B. 165 degrees – Casseroles and for all poultry – including ground chicken and turkey.
 - C. 160 degrees – Ground Beef and Pork, unpasteurized eggs and egg products are not allowed.
 - D. 145 degrees – Whole cuts of beef, pork, veal, lamb, fish (allow meat to rest for three minutes before carving and eating)
 - E. >135 degrees – Ready to eat foods needing heating before consumption should be taken from intact package and heated.

REFRIGERATE PROMPTLY

- Keep refrigerator temperature at/below 40 degrees and freezer at/below 0 degrees.
- Refrigerate perishable foods within 2 hours. If outside temperature is 90 degrees, refrigerate within one hour.

THROW IT OUT

- When in doubt, throw it out! Food/beverage with passed manufacturer's expiration dates will be discarded.
- All Leftover resident foods brought in from the outside should be consumed or discarded within three days.
- All other fresh/perishable foods brought in from outside the facility (opened and/or without a manufacturer's expiration date) should be marked with resident name, content, current date and discarded within 7 days.

Reviewed 07/19

II ADMISSION/DISCHARGE/TRANSFER

ADMISSIONS PROCEDURE

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

An application is then filed out and returned to the Social Worker or Admissions Coordinator 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 Committee and placement is determined. At the time of admission, every effort will be made to choose a suitable roommate, if indicated.

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

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

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

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

Pneumovax (if applicable)

Influenza Vaccine (as available/appropriate time of year)

Reviewed 07/19

NEW ADMISSION DOCUMENTATION GUIDELINES

1. Date, time and room number of admission.
2. How did the resident arrive, from where were they admitted, who accompanied them upon admission? If they were admitted from the hospital then it is important to note their days of stay at the hospital or days of stay at another facility or level of care.
3. Reason for admission and other pertinent diagnoses, especially the reason why they will be skilled for services. **VERY IMPORTANT!**
4. The LN will complete the assessments (located in PCC) and other documentation as outlined on the Admission checklist.
5. The baseline care plan will be instituted and shared with all pertinent disciplines and direct care staff.
6. The LN will place the resident on the alert charting log.
7. The LN will utilize the new admit progress note and/or Med A progress note to document pertinent Q shift assessments and health status.

Revised 01/2015, 07/2019

DISCHARGE OF A RESIDENT

Once a discharge plan has been formulated, all disciplines need to work toward expediting the discharge in a timely and error-free manner. The following issues must be addressed:

1. Discharge order signed by a physician
2. Outpatient prescriptions written and/or filled
3. Discharge or transfer summary completed with pertinent information
4. Check valuables list to make sure all items listed are accounted for
5. Obtain special diet information or specific prosthetic devices needed if resident is going to home setting or shelter care environment
6. Interface with home health for follow on care if indicated and ordered
7. Anticipate needs of resident in transfer and reassure him/her if problems are verbalized

Reviewed 07/19

PROPERTY 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 resident'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 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 07/19

CENSUS PROCEDURE

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

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

1. Admissions

All new admissions for the preceding 24-hour period, will be Listed by name, time they arrived, where they were admitted from, and what room they were put in.

2. Discharges

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

3. Room and Bed Transfers

RNC to note any room or bed transfers in the last 24 hours by indicating from room and bed and the to room and bed.

4. 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.

5. Hospital Leave/Return

All residents receiving acute care treatment will be listed by name. Time the resident left ISVH- Lewiston and where the resident went. If applicable, time the resident returned.

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

Revised 07/19

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CENSUS REPORT FORM

IDAHO STATE VETERANS HOME - LEWISTON
DAILY CENSUS REPORT

Date: _____

BEGINNING 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

ENDING CENSUS _____ RN Signature: _____

24-HOUR REPORT

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

This book is maintained at the nurse's station and is to be reviewed by nursing staff each shift.

Reviewed 07/19

IN-SERVICE EDUCATION

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

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

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

The Staff Development Coordinator will arrange for a minimum of two hours of in-service per month. Some months there will be more so employees may choose which ones are convenient and interesting to them.

1. The in-service will be scheduled at a time convenient to two shifts when possible.
2. The Staff Development Coordinator will post in advance a notice stating the time, topic and date of the in-service.
3. Off-duty employees will be encouraged to attend in-services, although attendance is not mandatory.
4. If the notice is marked “MANDATORY,” all staff must attend. Any employee not able to attend a “MANDATORY” in service must notify their supervisor for an alternate training option prior to the scheduled training.
5. Inservice education is compensated and direct care staff shall plan to attend before or after their scheduled shifts. If for any reason this is not possible, prior approval from your supervisor is needed.
6. The in-service schedule will include:
 - a) Safety & Emergency Procedures
 - b) Resident Rights & Advanced Directives
 - c) Effective Communication
 - d) QAPI Program
 - e) Person Centered Care/Trauma Informed Care
 - f) Cultural Competency
 - g) HIPAA Privacy and Security
 - h) Respectful Workplace
 - i) Ethics and Compliance
 - j) Infection Control
 - k) Dementia Management; Abuse and Neglect; Exploitation and Misappropriation
 - l) Required Competencies

Revised 01/2020

IN-SERVICE HOURS

1. Prior to any education, an Attendance Record will be completed for the staff to sign showing their attendance. This should include the items educated on, the date, the time the training lasted, and the instructor. Each session should have its own attendance form. Do not combine different days and sessions into one.
2. After the education, give your Attendance record to the Staff Development Coordinator. If a copy is needed for yourself, take that prior to handing it off.
3. The education hours will be inputted into the Inservice Management System monthly and at the end of each month, the total number of in-service hours each employee has earned will be totaled. Competency sheets will be updated monthly with this report as well.
4. Each Department Head will be given or emailed a print out of total hours for each employee as well as a Delinquent Inservice Hours report.
5. The Department Head is responsible to share the information with their employees and counsel them on the importance of maintaining their monthly goals for the annual hours and attendance for mandatory trainings.
6. The Staff Development Coordinator will be responsible for ensuring that all nursing employees have accumulated their mandatory 2 hours of monthly training to ensure that their 24 hours of in-services for the year is met. He/she will also update and monitor the competency records to ensure that staff are meeting their requirements.
7. If a Nursing employee is not meeting the requirement of 2 hours of in-service monthly, the Staff Development Coordinator will discuss with the employee a plan on how the employee will succeed in meeting the requirement and then closely monitor this.
8. If the employee has not received 24 hours of in-service credit by the end of their year, the Staff Development Coordinator will notify the DNS and HR of the issue and move to disciplinary action as necessary.
9. If an employee attends an outside seminar or course, they must report the following in writing through a handout or CEU form to the Staff Development Coordinator/RN Manager for input into the tracking system.
 - a. Date of class
 - b. Topic
 - c. Number of classroom hours
 - d. Instructor
 - e. Location

Reviewed 01/2020

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

Reviewed 07/19

RESIDENT TRANSPORTATION/TRANSFER

Emergency Transport

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

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- a. Documents sent with the resident to the hospital will be placed in the "Bed Hold Policy" envelope. These documents include the face sheet, POST, medication list, and transfer form.
- b. The LN will enter a discharge note into PCC and must include that a copy of the transfer form was given to the resident.
- c. Leave the copy of the transfer form in the Ward Clerk's box to be scanned into the resident's medical record.

Reviewed 07/19

APPOINTMENTS AND TRANSPORTS

When an order to transport or need for an appointment is indicated on a resident's order, the following procedure will be followed.

1. The Ward Clerk will note the appointment on the order and will make a reminder to make the needed appointment with the physician noted and within the time frame the order specifies.
2. The Ward Clerk will enter appointment into the transport calendar and notify the resident and/or their representative. If family wishes to transport, note that on the appointment/transport calendar.
3. The Ward Clerk will prepare the needed paperwork prior to the appointment and notify the Transport Aide of the location of the needed documentation packet to take with the resident.
4. The calendar will be checked daily by the Transportation Aide and Ward Clerk to ensure that there are no conflicting appointments.
5. If there are conflicts with appointment times, the Ward Clerk will attempt to reschedule.

Reviewed 07/19

HEALTH CARE FACILITY TRANSFER POLICY

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

Social Services coordinates all transfers.

1. The Social Service designee will work with resident and/or family in determining the transfer facility of choice. They will provide copies of the medical records and send prior to transfer to assure continuity of care for the resident. Copies to include:
 - a) Physician progress notes
 - b) Medication Administration Record and Treatment Record
 - c) Physician recaps
 - d) Current MDS
 - e) Nursing Progress Notes
 - f) Most recent lab and x-ray results
 - g) Resident demographic information
 - h) POST and Advanced Directives on file
 - i) Other records as deemed necessary
2. Nurses will obtain an order for the transfer at the request of the Social Services department.
3. Social Services will notify resident and/or family of transfer arrangements and document their discussions.
4. Social Services, in coordination with Nursing, will work with pharmacy to provide the needed medications upon transfer.
5. Social Services will implement the Discharge Instruction form during the planning stage and the Interdisciplinary Team will be notified of the need to complete their information prior to discharge.
6. Social Services will document their required information in their progress notes at the time of discharge.
7. The LN will document the required information (as per protocol and standards of nursing) in the progress notes at the time of the transfer/discharge. The documentation should also include physical condition of resident, mode of transportation, date and time leaving the facility and records sent.

Reviewed 07/19

RESIDENT CARE PLANNING

Standard:

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

Policy:

- A Baseline care plan is initiated upon admission of a resident.
- After nursing assessment is completed the LN completing the admission nursing assessment will add to the care plan pertinent information and directives on how to care for the resident.
- The comprehensive care plans are to be fully developed within 21 days following the resident's arrival in the facility.
- During the interdisciplinary team meetings. The team will complete the baseline care plan, then once the comprehensive care plan is developed, the team will review quarterly and when there is a change of condition, status, order, etc. With this review, the team will review and update the care plan as necessary.
- Each discipline is responsible for following the established format for care planning of the long-term care facility.
- Interdisciplinary cooperation should be evident in plans of care, when appropriate.
- Baseline care plans are "Hard" copy and kept in a binder at the nurse's station. Comprehensive care plans are in PCC.

Procedures

1. Assessment
 - a) A functional nursing assessments is conducted by using the admission nursing assessment and MDS.
2. Diagnosis
 - a) Resident needs are discussed and prioritized by the resident, family, and interdisciplinary team
 - b) Nursing diagnosis(s) are developed and placed in the Resident Care Plan
3. Planning and Setting Goals
 - a) Planning and setting goals are, whenever possible, a team effort by health care personnel, resident, and family.
 - b) Goals are individualized and realistic for the individual involved.
 - c) Goals must be stated in terms of behavior that is both specific and measurable within a given time.
4. Implementation
 - a) Action or nursing intervention is specific and relates to each stated goal.
 - b) Interventions are stated so that caregivers new to the resident can carry out care with complete continuity.
5. Evaluation

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- a) Progress on focus achievement is evaluated on the date set, typically 90 days from implementation.
 - b) If the goal has been achieved, then the goal may be reworded to something more applicable or the entire focus resolved.
 - c) If progress is slow, a new time frame may be established, and actions adjusted to meet the resident needs.
 - d) Each focus, goal and intervention is reviewed and updated by the Interdisciplinary Team at least quarterly.
6. Responsibility
- a) The resident care plan specifies the team member responsible for providing care or service and indicates how frequently specific services are being provided.

Revised 07/19

III ASSESSMENTS

BLADDER ASSESSMENT AND RETRAINING

Purpose:

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

Procedure:

Bladder Incontinence Evaluation

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

Bladder Retraining/Toileting Assessment

1. When a decision is made to consider a resident for participation in a retraining or scheduled toileting program, the Restorative nurse will start the appropriate training.
2. Once the decision is made for bladder retraining the Restorative Nurse will implement the retraining program for 30 days. Each week the Restorative Nurse will document progress, or lack thereof in the progress notes. If the resident is unable to show progress in a 30-day period then discontinue the program. The Restorative Nurse will make recommendations for staff to follow such as routine toileting program.
3. The routine toileting program is as follows: take to bathroom upon rising, before meals, after meals and at bedtime and PRN.

Reviewed 08/19

UTI ASSESSMENT PROTOCOL

Purpose:

To assess a resident properly for a Urinary Tract Infection prior to antibiotic use.

UTI WITHOUT CATHETER

Resident must have at least one sign or symptom + microbiologic criteria (i.e. Positive Urine Culture)

- a) Acute Dysuria
- b) Acute Pain
- c) Swelling
- d) Tenderness of the testes, epididymis or prostate

OR

1. Fever or Leukocytosis **and at least one** of the following localizing urinary tract subcriteria:
 - a) Acute costovertebral angle pain or tenderness
 - b) Suprapubic pain
 - c) Gross Hematuria
 - d) **New or marked** increase in incontinence
 - e) **New or marked** increase in urgency
 - f) **New or marked** increase in frequency
2. In the **absence of fever or leukocytosis, then one** of the following localizing urinary tract subcriteria:
 - a) Suprapubic pain
 - b) Gross Hematuria
 - c) **New or marked** increase in incontinence
 - d) **New or marked** increase in urgency
 - e) **New or marked** increase in frequency

Positive Urine Culture

1. At least 100,000 cfu/ml of no more than two species of microorganisms in a clean catch voided urine sample.
2. At least 100 cfu/ml of any number of organisms in a specimen collected by in and out catheter.

UTI WITH INDWELLING CATHETER

Resident must have at least one sign or symptom + microbiologic criteria (i.e. Positive Urine Culture)

- e) Acute Dysuria
- f) Acute Pain
- g) Swelling
- h) Tenderness of the testes, epididymis or prostate

OR

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1. Fever or Leukocytosis **and at least one** of the following localizing urinary tract subcriteria:
 - a) Acute costovertebral angle pain or tenderness
 - b) Suprapubic pain
 - c) Gross Hematuria
 - d) **New or marked** increase in incontinence
 - e) **New or marked** increase in urgency
 - f) **New or marked** increase in frequency
 - g) Either acute change in mental status **OR** acute functional decline, with no alternate diagnosis and leukocytosis.
2. In the **absence of fever or leukocytosis, then one** of the following localizing urinary tract subcriteria:
 - a) Suprapubic pain
 - b) Gross Hematuria
 - c) **New or marked** increase in incontinence
 - d) **New or marked** increase in urgency
 - e) **New or marked** increase in frequency

Microbiologic Criteria

1. At least 100,000 cfu/ml of any number of organisms.

Reviewed 08/19

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

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

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

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

Reviewed 08/19

DENTAL SERVICES ASSESSMENT

1. Requests for dental services shall be ordered by the resident's primary physician and the facility shall make arrangements for dental services.
2. 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.
3. If a resident refuses treatment, it is noted in the medical record by the medical provider or licensed nurse.
4. Dentures shall be labeled by the Ward Clerk or designee.
5. The resident's care plan shall be updated by the RN MDS Coordinator or designee as applicable.

Revised 08/19

NEUROLOGICAL ASSESSMENTS

Policy:

Residents that have a fall with a suspected head injury, an unwitnessed fall, or any other condition (Change in level of consciousness), which warrants neurological checks will have a Neurological Assessment completed.

Procedure:

A Neurological Assessment will be initiated immediately following initial nursing assessment after an incident or change in level of consciousness. Assessment is to be completed on the attached form by a Nurse. All actual/suspected head injuries are to be reported to MD within 24 hours. If actual head injury with positive neurological assessment, the MD will be immediately notified. When assessment is initiated the form will be kept in the Medication/Treatment books. After neurological assessment is completed, the completed form will be filed in the medical record.

Procedure is as follows:

1. Neurological assessment Q 15 minutes X 4
2. Neurological assessment Q 30 minutes X 4
3. Neurological assessment Q 1-hour X 4
4. Neurological assessment Q 4 hours X 4
5. Neurological assessment Q 24 hours X 2.

Revised 08/19

HEARING SERVICE

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.

Reviewed 08/19

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; 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 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 as to which residents are due, the type of assessment to be done and when the assessments/RAI components are due to assure the facility is maintaining compliance with timeframes.
- c) In the event of a Significant Change In Status, a comprehensive assessment will be done with any major decline or improvement which meets the following criteria:
 - i. Condition will not normally resolve itself without further interventions, is not self-limiting (for declines only).
 - ii. Condition impacts more than on area of resident's health status (Refer to RAI manual that will give more specific information).
- d) Condition requires interdisciplinary review/revision of the care plan. Assessments MUST be complete by the timeframes outlined by the RAI manual. There are no exceptions. This is needed to stay in compliance with regulations as well as transmission.
- e) The entry tracking record will be completed by the MDS Coordinator.

4. DISCIPLINES' RESPONSIBILITIES FOR RAI PROCESS

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

Nursing:

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

Social Services:

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

Activities:

- #10-Activities

Dietary:

- #12-Nutritional Status

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

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

Reviewed 07/19

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.

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

Procedure:

1. Considerations:

- a. A comprehensive Pain Assessment shall be done quarterly and as identified appropriate in the event of a change in the resident's pain med regimen and/or frequency, severity of pain.
- b. Subsequent pain assessments shall be done utilizing the Pain Assessment Worksheet – Quarterly & PRN form.
- c. Medications used to treat chronic pain should be given on a regularly scheduled basis.
- d. Medication for breakthrough pain is often necessary when treating chronic pain.
- e. The common side effects of narcotic analgesics can usually be managed and do not require discontinuing the narcotic.
- f. Pain control measures used for residents who are able to communicate should also be considered for residents unable to communicate their pain due to severe dementia, aphasia, or other causes.
- g. If resident demonstrates or voices pain during care interventions then staff shall immediately report status to licensed nurse for follow-up.

Process:

1. Perform a pain assessment utilizing/completing the pain assessment in electronic medical record.
 - a) Whenever possible, obtain all information directly from the resident. When the resident is unable to participate, obtain information from caregivers and family members.
 - b) In some cases, use behavioral cues to gather information.
2. Review the resident's current pain medication regimen to determine the following:
 - a) Name of drug, dose, and frequency ordered.
 - b) How long the resident has been on this medication.
 - c) Degree of relief experienced from this medication.

Managing Pain:

1. In treating pain, the following is recommended:
 - a) 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 Tylenol or non-steroidal 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.
 - b) For moderate pain, the use of a medication containing codeine (Tylenol 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 may also be used, either alone or in conjunction with medication.
 - c) 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.
 - d) 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.
2. If resident receives a regularly scheduled pain medication then pain shall be assessed a minimum of every shift and interventions implemented as appropriate.
3. When treating pain, start with a drug appropriate to the resident's current level of pain.
4. Residents 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.
5. 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.
6. Monitor to ensure that total dosages (regularly scheduled + PRN) do not exceed allowable daily dosages. (e.g., Tylenol should not exceed 9 {325mg.} tabs (or 3000 mg) in 24-hour period.)
7. 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)
8. Assess and document pain using an appropriate pain scale prior to and after administration of PRN analgesics.
 - a) Document level of pain: Level 0-10. If resident unable to verbalize, then evaluate pain relief using observable/behavioral pain cues.
 - b) Document source of pain, reason for administering pain medication and /or other pertinent information on the sheet.
 - c) To evaluate effectiveness, use the pain rating scale Level 0-10 if appropriate or document results of the pain medication based on resident's observable and behavioral cues.

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9. Whenever the resident demonstrates or voices pain, or if the resident uses an increasing number of PRN pain med doses, or if pain is not decreased following administration of pain medicine, or if pain rating remains 6-10, then the attending physician or RN Manager shall be notified.
10. Management of the side effects of analgesics is the joint responsibility of the attending physician and the nursing staff.

MDS Process:

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

Resident Care Plan:

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

Revised 08/19

SKIN ASSESSMENT

Purpose:

The Braden Scale 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. Form is found under Assessments tab in PCC.

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

1. The Skin assessment form (located in the Admit Nursing Assessment) shall be completed on each resident upon admission.
2. A Braden Skin Assessment will be completed quarterly, annually and in the event of a significant change of condition.
3. The Braden Skin form is designed to assess the resident condition/status as it relates to sensory perception, exposure to moisture, activity, mobility, nutrition, potential for friction and shearing. For each of the above areas assessed there is typically only one category (Severe/High Risk, Moderate Risk, Mild risk) that best describes the resident's current condition.
4. Based on the resident's assessment in each of the areas appropriate interventions shall be implemented to assist in maintaining skin integrity and/or healing skin problems.
5. Upon completion of the assessment form it is the expectation that the MD/Skin Wound nurse will update the care plan as appropriate.
6. Assessments will be periodically reviewed by the RN Manager, DNS, or designee for further intervention as appropriate.

Revised 08/19

SKIN CONDITION PROCEDURE

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

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

1. **Arterial Ulcer:** An ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis, inadequate blood supply to the extremity may initially present as intermittent claudicating Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders, or significant vascular disease elsewhere, (e.g. stroke or heart attack). The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g. top of the foot or toe, outside edge of the foot) The wound bed is frequently dry and pale with minimal or no exudates. The affected foot may exhibit diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down or increased pain when elevated, blanching upon elevation, delayed capillary till time, hair loss on top of the foot and toes, toenail thickening.
2. **Diabetic Naturopathic ulcer:** Requires that the resident be diagnosed with diabetic mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs (on the foot, e.g. at mid foot and the ball of the foot over the metatarsal heads, or on the top of toes with Charcot deformity.
3. **Venous Insufficiency Ulcer:** (known as “stasis ulcer”) is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are to the most common vascular ulceration and may be difficult to heal, may occur off and on for several years and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial and may have a minimal to copious serous drainage unless the wound is infected. May experience pam which may be increased when the foot is in a dependent position, such as when a resident is seated with feet on the floor.
4. **Pressure Injury:** The facility must ensure that a resident who enters the facility without a pressure injury does not develop a pressure injury unless the individual’s clinical condition demonstrates that they were unavoidable.
 - A. **Definition of a Pressure Injury:** A pressure injury is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure injuries, friction and shear are important contributing factors to the development of pressure injury.
 - B. **Avoidable/Unavoidable Pressure Injury:**
 - i. **Avoidable:** Means that the resident developed a pressure injury and that the facility did not do one or more of the following: evaluate the resident’ clinical condition and pressure ulcer risk factors: define and

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implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice, monitor and evaluate the impact of the interventions: or revise the interventions as appropriate.

- ii. Unavoidable: Means that the resident developed a pressure injury even though the facility had evaluated the resident's clinical condition and pressure injury risk factors: defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice: monitored and evaluated the impact of the interventions and revised the approaches as appropriate.

C. When a resident is admitted with or develops a pressure injury the following steps must be taken:

1. A complete assessment must be done, this assessment must contain the following:
2. Factors that influenced its development e.g. disease process(s)
3. Determine the injury's stage using the following definitions:
 - a. Stage I - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: Skin temperature (warmth or coolness), Tissue consistency (firm or boggy), sensation (pain, itching) and/or a defined area of persistent redness in lightly pigmented skin.
 - b. Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The injury is superficial and presents clinically as an abrasion, blister, or shallow crater.
 - c. Stage III - Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The injury presents clinically as a deep crater with or without undermining of adjacent tissue.
 - d. Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.
NOTE: if Escher and necrotic tissue are covering and preventing adequate staging of a pressure injury, the RAI User's Manual Version 2 instructs the assessor to code the pressure ulcer as a Stage IV.

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4. Wound Description:
 - a. Describe the injury's characteristics.
 - b. Determine if infection is present.
 - c. If pain is present.
 - d. Treatment indicated.
 - e. Interventions in place for prevention or needed to promote healing.
 - f. Nutrition/skin committee notified.
 - g. MD notified.
 - h. Family notified and in agreement with treatment.
5. Place on the TAR to be assessed as scheduled.
6. The day shift will do all decubitus treatments. The weekly pressure ulcer record will be completed by the Skin/Wound nurse and copies given to the DNS and reported to QAPI as appropriate.

Revised 08/19

SMOKING

Purpose:

Smoking procedures for this facility are necessary for ensuring the safety of each resident, staff, 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. A copy of the Smoking Policy will be distributed to resident on admission.

Procedure:

- A. Resident smoking is allowed only in designated smoking areas around the facility.
- B. Smoking materials, both tobacco and electronic, will be kept at the Nurses' Station in a locked cupboard.
- C. Residents who wish to smoke will be assessed using the Smoking Classification Assessment tool located in PCC. The IDT team will review the assessment and resident history to make an informed decision as to which category the resident needs to be placed in.
- D. Individuals who wear oxygen and smoke tobacco products must remove oxygen prior to smoking. Individuals who do not wear oxygen and smoke tobacco products will not smoke by a resident who is wearing oxygen
 1. Without Supervision:
 - a) These residents will be given cigarettes and/or electronic cigarette upon request.
 - b) These residents will be allowed to come and go from the smoking areas unattended.
 - c) These residents have scored 12-15 on the BIMS.
 2. Supervision & Limited Supervision:
 - a) Assist resident to smoking area
 - b) Assist with donning of smoking apron as appropriate
 - c) Ensure no resident with Oxygen is within 10 feet of the resident smoking
 - d) Assist to remove oxygen tank and secure if necessary
 - e) Assist resident to light cigarette.
 3. Extensive Supervision:
 - a) The facility will talk with the family and resident in regard to the facility smoking schedule. They will encourage family to assist resident with complying with the policy set above. One staff member will observe and assist those residents that fall in this category during scheduled smoking times. Staff will monitor that no resident who is wearing oxygen is within 10 feet of the smoking area.
- E. Resident's care plan will be adjusted to reflect their smoking assessment and classification, along with other related smoking interventions.
- F. Resident's smoking abilities will be re-assessed in the event of a change of condition or at least quarterly. Staff and visitors must smoke outside the facility in designated areas only.

Revised 08/19

VISION SERVICES/ASSESSMENT

1. Requests for optical services shall be ordered by the resident's primary physician and the facility shall make arrangements for vision/optical services with the resident's preferred provider.
2. Eye glasses shall be labeled by the Ward Clerk or designee.
3. The resident's care plan shall be updated by the MDS Coordinator or designee as applicable.

Revised 08/19

MINI MENTAL STATUS (MMS) FOLSTEIN

A BIMS will be completed upon admission on each resident, then quarterly and in the event of a significant change in condition.

Revised 08/19

BOWEL MANAGEMENT PROTOCOL

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 electronic medical record 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 orders are already in place) for progressive bowel elimination intervention.
4. Completed bowel work sheet shall be submitted to unit RN Manager or designee 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.

Reviewed 08/19

RESIDENT WEIGHTS/NUTRITIONAL EVALUATION

Resident Weights

1. Upon admission, the resident will be weighed daily x 3 days and then weighed weekly x four.
2. Weights will typically be obtained on each resident once a month by a Restorative Aide. Weights will be recorded in the electronic medical record.
3. Re-weights will be obtained on each resident whose previous month's weight, compared with the current weight, is plus (+) or minus (-) five (5) pounds.
4. Re-weights will be obtained on each resident whose previous week's weight, compared with the current weight, is plus (+) or minus (-) three (3) pounds.
5. Re-weights will be obtained upon discovery of the weight differences and both weights will be recorded onto the resident's weight sheet.
6. On a re-weight, the weight closest to the previously recorded weight will be used as a basis for further interventions.
7. Nutrition At Risk (NAR) committee will review residents and add or DC weekly weights per resident review.

Evaluation:

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

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

Revised 08/19

POLICY AND PROCEDURE FOR MONITORING PSYCHOTROPIC MEDICATION SIDE EFFECTS

Assessments: Abnormal Movement Scale

Policy Statement:

An abnormal movement scale (AIMS) assessment shall be completed on all residents receiving/discontinuing anti-psychotic medications.

The Social Worker in cooperation with Nursing will complete AIMS at the scheduled time.

- A. Ongoing Testing: All individuals currently taking neuroleptic medication shall be assessed once every 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-L shall have an initial screening within one month of admission.
- C. Increase of neuroleptic medication:
 - a. Within one month but not before seven days following the increase or decrease of the medication.
 - b. Every six months thereafter.
- D. Discontinuance: Any resident whose neuroleptic medication is discontinued shall be screened after the discontinuation at the following intervals:
 - a. One Month
 - b. Three Months or
 - c. Whenever the prescribing practitioner determines and documents that the individual does not have TD.
- E. Individuals showing signs of TD will be referred to the physician for the purpose of evaluation, diagnosis, and treatment recommendations.
- F. The AIMS testing form shall be found in the "Assessment" section of the electronic medical record.

Revised 08/19

PRN PSYCHOTROPIC MEDICATION ASSESSMENT

Procedure:

Prior to the use of a PRN psychotropic, hypnotic, or anti-anxiety medication (when considered for use for behaviors - not related to comfort care and/or air hunger), the licensed nurse will assess the resident for possible causes and/or alternative interventions. PRNs cannot exceed 14 days. Refills will be supported by primary physician's reassessment and documentation.

Revised 08/19

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 cause of the wound, if possible, e.g. shoes, mattress on bed, rubbing on something. Remove or change the cause.
2. Obtain an order for an appropriate treatment.
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
 - c. Any drainage or odor
 - d. Wound Measurement (e.g. the surrounding tissue is pink and blanching)
 - e. If pain is present on palpation
 - f. Cause 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 RN Manager, leave a voicemail, call at home, note under the office door, etc.
8. Notify the MD.

Reviewed 08/19

IV RESIDENT INCIDENT/ACCIDENT REPORTS

INCIDENT /ACCIDENT WORKGROUP

Purpose:

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

Procedure:

1. A multi-disciplinary workgroup shall be established to include the Director of Nursing Services, or designee, and representation from Social Services, Activities, Dietary, and any other individuals the members may deem necessary to assist the workgroup.
2. The workgroup shall meet at 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. Trending reports related to incidents and accidents will be generated and analyzed on a monthly basis (more often when deemed appropriate) for presentation in the QA meeting.

Revised 08/19

RESIDENT INCIDENT REPORT

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

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

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

Procedure:

1. Any individual aware of an incident/accident involving a resident shall report the incident directly to the licensed nurse on the specific resident's unit. If the resident was involved in a fall the CNA is not to assist resident up prior to the LN doing a head to toe assessment and ROM to ensure there is no injury prior to getting the resident off the floor.
2. The Risk Management Tool, in electronic health record, is to be initiated and completed by the attending nurse by end of the shift in which the incident occurred or was reported.
3. Alert Charting, as appropriate will be initiated.
4. The DNS or designee will report the incidents to the Incident and Accident workgroup for multidisciplinary evaluation and/or any further interventions.

Revised 08/19

RESIDENT-TO-RESIDENT ALTERCATION

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

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

Reviewed 08/19

FALL RISK ASSESSMENT

PURPOSE: To provide a tool to assist in determining a resident's risk for fall and to assist staff in implementing appropriate interventions to reduce/eliminate fall incidence(s).

PROCEDURE:

1. A Fall Risk assessment will be completed when a resident is admitted to the facility.
2. A Fall Risk assessment will also be completed quarterly, in conjunction with the resident's MDS schedule and in the event a significant change of condition is identified.
3. Based on the assessment's risk category and score and other information available related to the resident's history, medication regimen, diagnosis, etc., interventions will be implemented, and care planned to try and reduce or eliminate falls.

Revised 08/19

V NURSING POSITION DESCRIPTIONS

POSITION DESCRIPTIONS

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

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

Reviewed 08/19

VI CARES

RESIDENT CARES GUIDELINES

Procedure:

1. The AM, PM, and NOC cares provided to residents in this facility will be documented in the electronic health record.
2. In the event a resident either refuses or resists any of the cares offered then the aide assigned the resident shall indicate this refusal or resist as an R” in the appropriate box. The resident’s refusal or resistance to care(s) shall be communicated per above and to the licensed nurse assigned the resident at the time of occurrence. The licensed nurse shall assess situation and determine appropriate course for further interventions and document actions/findings in the nurse progress note section of the medical record.

Protocol:

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

AM Cares:

- Dressing/assisting resident in appropriate clothing
- Providing oral hygiene
- Washing face & hands
- Combing/brushing hair
- Shaving resident as needed
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room
- Passing Water/Ice
- Tidying room
- Applying appropriate support devices as ordered/care planned
- Placing call light within reach of resident
- Repositioning resident as needed
- Offering fluids
- Setting up/assisting resident with meal(s)
- Ambulating/transferring resident as needed
- Cleaning wheelchairs weekly + PRN
- Checking residents’ skin, report red or open areas to licensed staff
- Reporting BM status to licensed staff
- Obtaining vital signs as directed by licensed staff

PM Cares next page

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PM Cares

- Dressing/assisting resident into appropriate bed clothing
- Removing dentures
- Providing oral hygiene
- Washing face & hands
- Shaving resident as needed
- Combing/brushing hair
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room
- Passing Water/Ice
- Tidying room
- Applying appropriate support devices as ordered/care planned
- Placing call light within reach of resident
- Repositioning resident as needed
- Offering fluids
- Setting up linens/blankets/pads as needed
- Setting up/assisting resident with meals
- Ambulating/transferring resident as needed
- Check residents' skin report red or open areas to licensed staff
- Obtaining vital signs as directed by licensed staff

NOC Cares:

- Changing resident clothing as appropriate
- Washing face & hands (if applicable)
- Toileting/Peri-Care as appropriate
- Removing soiled linen/clothing from room
- Passing Water/Ice
- Tidying room
- Applying appropriate devices/restraints as ordered
- Placing call light within reach of resident
- Repositioning resident as needed

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

Reviewed 08/19

GAIT BELTS FOR TRANSFER AND AMBULATION

Policy:

Gait belts are provided to nursing staff employees to ensure safe transfer of residents or safe ambulation of residents. Gait belts are to be used for each resident that requires assist with transfers or ambulation unless contraindicated. Gait belts will never be used as a form of a restraint.

Gait belts will be issued to each new nursing employee upon hire during the orientation process. At this time, the employee will view a video on proper mechanics and correct procedure for use of a gait belt in transfers and ambulation.

Each employee issued a gait belt will be expected to have it on his or her person when reporting to work. The Idaho State Veterans Home will purchase the first gait belt. If an employee loses their issued gait belt, it will be up to the employee to procure another one.

During the new employee orientation process any new nursing employee will read and sign the Policy and Procedure on Gait Belts for Transfers and Ambulating. The new employee will also sign a statement that they have been issued a gait belt, the gait belt will be on their person when reporting to work, the employee will use the gait belt appropriately and if lost, the employee will procure a new one at their cost.

Procedure:

1. Explain procedure to resident. When transferring to/from bed to wheelchair or wheelchair to bed, ensure the brakes on wheelchair and bed are locked.
2. Apply belt around resident waist. The gait belt is not to be next to resident skin. Apply over clothing.
3. Ensure the belt is snug but allow enough room for your hand to comfortably grasp it.
4. Stand as close to the resident as possible, maintaining a broad base of support.
5. To Transfer:
 - a. Assist resident to a standing position by grasping belt at the waist from underneath.
 - b. Pivot resident into chair or bed.
6. To Ambulate:
 - a. Assist resident to standing position by grasping belt at the waist from underneath.
 - b. Standing on weaker side of resident, wrap your arm around waist of resident and grasp belt from underneath.
 - c. Maintain a firm grasp on belt and proceed to ambulate.
7. When transfer and/or ambulating is completed, remove belt, ensure resident is safe and comfortable before leaving resident room.
8. Follow resident care plans as to 1 or 2 person transfer and/or ambulating.

Reviewed 08/19

TRANSFERS AND AMBULATION

PROCEDURE:

To ensure the safety of our residents, all residents requiring assistance with transfers or ambulation will be done by either licensed or certified staff only.

Any non licensed or non certified staff, volunteers, and contract staff will be instructed to ask licensed or certified staff to transfer or assist with ambulation of a resident.

All non licensed or non certified staff will be educated on hire (through their orientation program) the procedure for transfers and ambulation of residents.

All volunteers registered through the Volunteer program will be educated by the Volunteer Coordinator on the procedure during their orientation program prior to volunteering.

All contract employees will be educated on the procedure upon hire and annually through the Skills Fair topics.

Ongoing education regarding transfers and ambulation occurring only with Licensed staff or Certified personnel will be presented during our Annual Skills Fair and periodically throughout the year as the need or topic arises.

PERINEAL CARE

Residents should be given perineal care each a.m. and p.m. and more frequently if needed using perineal and skin cleanser. All residents wearing incontinent briefs will be checked on a regular basis for need of changing. Residents will be cleansed after incontinent episode.

Perineal and Skin cleanser are available and are kept at bedside for use during peri care.

Revised 08/19

SKIN CARE

To promote effective, timely application of skin lotion, creams, gel, and moisture barriers, the following procedures will be followed.

1. Skin protective lotion, creams, and/or moisture barrier cream may be kept at the resident's bedside and administered per direction from the LN.
2. The licensed nurse will administer medicated creams/gels, if they were ordered to treat an acute skin condition.
3. The aide is responsible for reporting any changes in skin condition to the LN for further evaluation.

Revised 08/19

PASSING OF ICE WATER

Ice Water will be passed to the residents each shift by the CNA assigned to the hall or if a float aide is available, the float aide will complete procedure.

Water will be offered to residents who normally cannot obtain independently. Water containers will be changed each day on the afternoon shift and sent to the kitchen for cleaning.

Reviewed 08/19

CLEANING OF URINALS

- Urinals are to be at bedside for resident use (when applicable).
- Urinals are to be checked frequently to ensure they are empty and rinsed.
- Urinals are to be collected and discarded on the 5th (Fifth) of each month. A new urinal is then given to each resident who chooses to use it, ensuring the urinal is labeled with their name and date replaced.
- For infection control purposes ensure urinals are not on same table as ice water or other food items, unless a resident insists it be there. Report to your nurse so appropriate interventions can occur.
- If staff assists a resident with the use of the urinal, then it should be stored in a plastic bag in the resident's bathroom.

Revised 08/19

BATHING PROCEDURE

Purpose:

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

Procedure:

Schedule:

1. Each unit's Resident Bathing Schedule will be developed per resident input/preference and updated by the Bath Aide and/or RN Manager or designee.
2. On day one of an admission or transfer to a wing a bathing schedule will be developed for the resident.
3. Bathing/showering will be conducted as scheduled. If a resident is unable or unwilling to bath/shower as scheduled -will be referred to the next day for follow up.

Documentation:

1. Bathing/showering of resident will be recorded on the specific resident in the electronic medical record.
2. If a resident refuses a bath/shower then the CNA will document in the ADL's section that the resident refused. Additional information about the refusal may also be documented in Medical Record under the Mood and Behaviors (3.0).
3. If a resident refuses a bath the licensed nurse assigned to that resident will be notified by the CNA.
4. Nurse assigned resident is responsible for ensuring the resident receives bath/shower per schedule and/or the resident's preference.

Bath Aide:

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

Revised 08/19

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. Wash hands before and after procedure and wear gloves.
4. Remove soiled appliance bag carefully, if applicable.
5. Open-ended appliance bags may be rinsed with lukewarm water and reapplied if the wafer is dry and intact.
6. Wash around the ostomy site 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 TAR as appropriate.

Reviewed 08/19

URINARY/INDWELLING/SUPRA-PUBIC CATHETER CARE

Purpose:

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

Procedures

1. Wash hands before and after any manipulation of the catheter site and/or apparatus.
2. Gloves are worn when contact with body fluids or secretions are expected.
3. Provide privacy.
4. Explain procedure to resident.
5. Use leg straps to properly secure catheter, being sure it is not too tight to not cause irritation or trauma.
6. The catheter and drainage tube should not be disconnected unless specified by a physician. If it is permitted by an MD order then follow directions below under “Use of leg bags”.
7. Change catheter when they become plugged, contaminated or foul smelling and per MD order. Catheter bags are changed weekly.
8. When emptying a catheter bag and opening the spout caution should be taken to not allow the end of the spout to touch anything that will contaminate it.
9. The catheter tubing must remain patent, with the drainage bag kept below the level of the bladder, to maintain unobstructed urine flow and prevent pooling and backflow of urine into the bladder.
10. Along with routine peri care, routine catheter care is performed Q shift. Use of a wash cloth, soap, and water is indicated with routine catheter care. Cleanse the proximal third of the catheter with soap and water, washing away from the insertion site and manipulating the catheter as little as possible to avoid trauma to the urethra.
11. Abnormal urine characteristics are reported to the LN and documented with MD notification if necessary.
12. If drain bag is changed to a leg bag, ensure ends of tubing do not touch anything that will contaminate it. Store unused bag in a plastic bag and/or container.

Revised 06/20

PROSTHETICS

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

Reviewed 08/19

FEEDING A RESIDENT

Purpose:

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

Procedure:

Feeding:

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

Assessment:

1. During the feeding/eating process, if a resident is noted to be pocketing food (food present in oral cavity – not swallowed completely), coughing or choking during any part of the meal consumption process, or voices or demonstrates any problems with eating all or any food offered; notify a licensed nurse.
2. If an eating/swallowing problem is noted, the licensed nurse will notify the physician for further follow up.

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SUCTION EQUIPMENT MAINTENANCE

1. Suctioning will be done when ordered by a physician or in the event of an emergency situation.
2. Suctioning will be administered by a licensed nurse.
3. Resident's requiring deep or tracheal suctioning will be referred to the RN Manager/DNS for evaluation and further intervention.
4. Suction machines are located on each of the north dining room and the main dining room.
5. Suction catheters and tubing will be dated when put into use and discarded after one week of use and PRN.
6. Canisters assigned to residents will be discarded when 2/3rds full of when suctioning is no longer necessary. Canisters will be disposed of by storekeeping staff upon notification.

Revised 08/19

VII RESIDENT ABUSE/NEGLECT

FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION

1. PURPOSE

Each resident at Idaho State Veterans Home –Lewiston 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- Lewiston 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-L requires all employees, managers, supervisors, agent, and contractors to report any reasonable suspicion of crimes committed against a resident. The Idaho State Veterans Home-Lewiston 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-L 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-Lewiston 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.

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- 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 – Lewiston. 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,

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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-Lewiston 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-L 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-L 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-L- 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-L 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

Lewiston City Police Department (208) 746-0171

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.

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“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-L 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-L 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-L 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-L 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-L, 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

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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.

- 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. The following steps will be taken with investigations:
 1. Interviews and obtains written, dated and signed statements from direct care staff assigned to resident. Depending on the incident, it may be necessary to obtain statements from direct care staff 1-2 shifts prior.
 2. Interviews and obtains written, dated and signed statements from staff witnesses or other available witnesses.
 3. If a staff member is implicated in the incident, the person will be instructed to discuss situation with the Administrator or the Director of Nursing.
 4. Continued facility investigation may occur, as needed, over the next 24-48 hours.
- 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.
 1. 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?
 - a. What did the staff do immediately to ensure the safety of both residents?
 - b. Was there any physical injury and if so, how was the injury addressed?
 7. What was the resident's emotional status?

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8. Who was notified: Administrator, DNS, DSS, family?
 9. Were there any changes in medication?
 10. Were there any recent changes in physical condition; i.e.: infection?
 11. Was the care plan amended?
- e. Nurse progress summary notes at the end of each shift for 72 hours may include:
12. The emotional state of the resident(s).
 13. Any verbal or physical aggression towards others.
 14. Any change in medication.
 15. Any physical changes.
 16. 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, 03/20

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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 Lewiston 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 – Lewiston.</p> <p><u>IDAHO STATE VETERANS HOME CONTACT:</u> Mark High, Administrator 821 21st Avenue , Lewiston, ID 83501 Phone: (208) 750-3600 Fax: (208) 750-3601 Email: mark.high@veterans.idaho.gov</p>	
Reported to the State Survey Agency? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Date Reported: ___/___/___ Time: _____ LEWISTON CITY POLICE DEPARTMENT CONTACT: 208-743-0171
<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, 12/17

BEHAVIORAL HEALTH SERVICES

Procedure

It is the procedure of this facility that all residents receive necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.

Definitions:

“Mental disorder” is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

“Substance use disorder” is defined as recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment, such as health problems or disability.

“Non-pharmacological intervention” refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident’s mental, physical, and psychosocial well-being.

“Mental and psychosocial adjustment difficulty” refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident’s typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms.

Procedure Explanation and Compliance Guidelines:

1. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident’s mental and psychosocial status and providing person-centered care. This process includes:
 - a. PASARR screening;
 - b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health;
 - c. MDS and care area assessments;
 - d. Ongoing monitoring of mood and behavior;
 - e. Care plan development and implementation, and
 - f. Evaluation.
3. The resident and family are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as appropriate. The care plan shall:
 - a. Be person-centered,
 - b. Provide for meaningful activities which promote engagement and positive, meaningful relationships;
 - c. Reflect the resident’s goals for care,
 - d. Account for the resident’s experiences and preferences, and

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- e. Maximize the resident’s dignity, autonomy, privacy, socialization, independence, and safety.
4. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment. Topics of training may include, but are not limited to:
 - a. Implementing non-pharmacological interventions;
 - b. Communication and interpersonal skills that promote mental and psychosocial well-being;
 - c. Promoting residents’ independence;
 - d. Respecting residents’ rights;
 - e. Caring for the residents’ environment and providing an atmosphere that is conducive to mental and psychosocial well-being;
 - f. Mental health and social service needs, and
 - g. Care of cognitively impaired residents.
5. Interventions shall be evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.
6. Behavioral health care and services shall be provided in an environment that promotes emotional and psychosocial well-being, supports each resident’s needs and includes individualized approaches to care.
7. Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated.
8. The facility may utilize individualized, non-pharmacological interventions to help meet behavioral health needs. Examples may include, but not limited to:
 - a. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);
 - b. Exercise;
 - c. Pain relief;
 - d. Individualizing sleep and dining routines;
 - e. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;
 - f. Adjusting the environment to be more individually preferred or homelike;
 - g. Consistent staffing to optimize familiarity;
 - h. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs;
 - i. Utilize techniques such as music, art, massage, aromatherapy, reminiscing;
 - j. Assisting residents with substance use disorders to access counseling programs to the fullest degree possible.
9. Behavioral health care plans shall be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.

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10. The Social Services Department shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists.

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F740** – Behavioral Health Services. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F741** – Behavioral Health Services. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F742** – Behavioral Health Services. 42 C.F.R. §483.40.

Revised 08/19

TRAUMA INFORMED CARE/CULTURE COMPETENCE

Policy:

It is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice.

Definitions:

“Trauma” is defined as an event, a series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being. Common sources of trauma may include, but are not limited to:

- a. Natural disasters
- b. Accidents
- c. War
- d. Physical, emotional, or sexual abuse at any age
- e. Rape
- f. Unexpected life events (death of a child, personal illness, etc.)

“Trauma-Informed Care” is defined as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

“Cultural Competence” is defined as the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations. Policies, structures, practices, procedures, and dedicated resources can support this capacity. Cultural and linguistic competency occurs through adopting and implementing strategies to ensure appropriate awareness of, attitudes toward, and actions about diverse populations, cultures, and language.

Policy Explanation and Compliance Guidelines:

1. Each resident will be screened for a history of trauma upon admission.
2. The facility social worker or designee will conduct the screening in a private setting.
3. If the screening indicates that the resident has a history of trauma and/or trauma-related symptoms, a physician’s order will be obtained for the resident to be evaluated by a mental health professional who is experienced in working with those exposed to trauma. The mental health professional should be licensed to assess, diagnose, and treat the resident accordingly.
4. Once the physician’s order is received, the social worker or designee will place the referral to the mental health professional.
5. The facility will account for residents’ experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Potential causes of re-traumatization by staff may include, but are not limited to:
 - a. Being unaware of the resident’s traumatic history
 - b. Failing to screen resident for trauma history prior to treatment planning

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- c. Challenging or discounting reports of traumatic events
- d. Endorsing a confrontational approach in counseling
- e. Labeling behaviors/feelings as pathological

- f. Failing to provide adequate safety
- g. Minimizing, discrediting or ignoring resident responses
- h. Obtaining urine specimens in a non-private setting

VIII PHARMACY

PHARMACY SERVICES

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

The pharmacist shall be responsible for:

1. Reviewing the medication profile for each individual patient at least every thirty (30) days.
2. Advising the attending physician of drug therapy duplication, incompatibilities, and/or contraindications.
3. Reviewing all medications in the in-house pharmacy and Pixys, if applicable, for expiration dates.
4. Removing discontinued or expired drugs from use at least every thirty (30) days.
5. Reviewing the narcotic drug records at least every thirty (30) days and certifying to the administrator that the inventory is correct.
6. 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.

Revised 08/19

DRUG DISPENSING TO FACILITY

Medication Labeling/Cassettes

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

Pharmacy Availability

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

Pharmacy Access

1. Access to the facility Pharmacy will be limited to the Director of Pharmacy Services and on-call pharmacist.

Reviewed 08/19

FLOOR STOCK PHARMACEUTICALS

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 cabinet for floor stock medications will be kept in the locked charge room.
2. Pharmacy staff will maintain inventory as well as a master list of all medications contained in the cabinet and will ensure that drugs are in adequate supply.
3. Licensed nursing staff will sign out medications on the appropriate forms when taken from the cabinet to include the name of the drug, date, and time of removal, signed with nurse's complete signature.
4. The pharmacist will be responsible for reviewing the sign-out sheets and restocking as necessary.

Revised 09/19

MEDICATION ADMINISTRATION & MEDICATION ORDERS

Responsibility

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

Medications/Medication/Treatment Carts

1. 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 fluids and food will be discarded after 24-hours (typically at the end of the night shift).
7. To protect the resident’s right to privacy, the PCC screen will be closed and identifying papers covered when the nurse is away from the cart.
8. Medications that have been set-up and not given or refused (also refer to Controlled Substances) shall be wasted.

Medication Administration

1. Nursing’s process (five rights) will be noted before the administration of each medication.
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.
 - d) Each order will specify who will administer the MDI order, e.g. resident or nurse.
5. The nurse will wait at least 3-5 minutes between each eye drop.
6. **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.).
7. Provide adequate fluids with medications.
8. Medications that require the nurse to “shake well” will be done just prior to administration.

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9. Insulin should be “rolled” to mix prior to administration.

Standard Medication Times and Orders

Per electronic health record medication times.

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

1. Verbal orders shall be taken by a licensed nurse, pharmacist, or physician.
2. 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, per PCC guidelines.
3. Licensed nurse noting the order shall remove the specific (discontinued or dosage changed) medication from the med cart and deposit in charge room or give back to pharmacist. (Note: if the medication is a controlled substance, contact pharmacist for proper disposal)

Medication Administration Documentation

1. Medications will be signed following administration.
2. PRN Medications will be charted as above with reason and results included in the charting.
3. When a resident refuses a medication, the nurse will document the reason in the electronic EMAR.
4. Injections will be charted with site of injection in electronic EMAR.
5. When a medication is not given within the scheduled time, then the nurse will document in the electronic EMAR, except PRN narcotic medication. PRN narcotic medication must be given at time frame specified by the MD order.
6. When a resident has a scheduled narcotic medication and a PRN narcotic medication, the PRN medication may be given no sooner than one (1) hour after the administration of the routine narcotic medication.

Revised 07/19

SELF ADMINISTRATION OF MEDICATION

Policy:

It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

Policy Explanation and Compliance Guidelines:

1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team.
2. Resident's preference will be documented on the appropriate form and placed in the medical record.
3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:
 - a. The medications appropriate and safe for self-administration;
 - b. The resident's physical capacity to swallow without difficulty and to open medication bottles;
 - c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;
 - d. The resident's capability to follow directions and tell time to know when medications need to be taken;
 - e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
 - f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.
 - g. The resident's ability to ensure that medication is stored safely and securely.
4. The results of the interdisciplinary team assessment are recorded on the *Self-Administration Assessment Form*, which is placed in the resident's medical record.
5. Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the *MAR*.
6. Only one signature per shift is required when documenting the resident's report of self-administration.
7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur:
 - a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective.
 - b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.

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8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary.
9. Medications stored at the bedside are reordered in the same manner as other medications.
10. The nursing staff is responsible for proper rotation of bedside stock and removal of expired medications.
11. When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the medication cart or medication room.
12. The care plan must reflect resident self-administration and storage arrangements for such medications.
13. Medication errors occurring with residents who self-administer will not be counted in the facility's medication error rate.
14. A re-assessment for safety at a minimum should be considered by the interdisciplinary team for the following:
 - a. Significant change in resident's status.
 - b. Medication errors occur.

MEDICATION ADMINISTRATION: FEEDING TUBES

Purpose:

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

Procedure:

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

Reviewed 09/19

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, feeding should be held if residual is > 100cc. (or per MD orders), document.
 - 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 30-45 degrees during and at least 30 minutes following each feeding.
8. Enteral feeding equipment shall be dated, stored, and changed appropriately.
 - a) Irrigation syringe shall be rinsed with hot water following each use, dated and stored (may be stored in the resident's room), and discarded every 24 hours.
 - b) Open formula systems shall not hang > 8 hours, or per manufacturers guidelines.
 - c) Tubing shall be discarded every 24 hours.
9. Staff shall use standard precautions when preparing and instilling the enteral feeding.

Revised 09/19

INJECTION AND DERMAL PATCH SITE DOCUMENTATION

Purpose:

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

Procedure:

1. Every injection/dermal patch order will have a designated time of administration and a site indication listed on the individual resident's E-MAR (Electronic Medication Administration Record).
 - a) Licensed staff will initial in the appropriate time/day/shift box after the medication is administered.
 - b) Licensed staff will indicate in the appropriate site box, the location of the injection site and/or placement site of the dermal patch per electronic E-MAR.

Reviewed 09/19

MEDICATION RECALL

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

Reviewed 09/19

MEDICATION STORAGE/DISPOSAL

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

Resident Medications:

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

Reviewed 09/19

MEDICATION/PRESCRIPTION RE-ORDERING

1. Medications packaged in bubble” packs will be dispensed starting in the top left corner or as near as possible to the blue arrow. Number will be 31, 60, or 90 depending on the amount of medications to be dispensed for that period.
2. Put the date the first dose starts next to the top left corner “bubble.”
3. When the medications have been dispensed down to the start of the blue column it is time to reorder.
4. The reorder procedure is the following:
 - a) Obtain pharmacy reorder form. Write on the form the following: the resident’s name, Rx number and date filled located in the top upper left corner of the card.
 - b) On the upper area of the card write R.O. with date and your initials to alert staff that the medication has been reordered.
 - c) Place the reorder form in the pharmacy box located at the nurse’s station.
 - d) If, after a reasonable time (1-3 days) the medication has not been refilled, please notify the pharmacist.

Reviewed 09/19

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
PRN Psychoactive	14 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 and/or provide justification for a re-order.
5. The Pharmacist will communicate with the nursing department their recommendations related to medication discontinuation in conjunction with the monthly drug regimen review.
6. The RNC (or designee) will initiate the physician notification and discontinuation order.

Revised: 07/19

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

Controlled Substance Inventory Count/Errors

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

Reviewed 09/19

**ACCIDENTAL BREAKAGE OR CONTAMINATION/PARTIALLY USED
CONTROLLED SUBSTANCES/WASTAGE**

1. The licensed nurse will summon another licensed nurse to co-sign the amount of the controlled substance that has been wasted.
2. In the witnessing wastage of controlled substances, the licensed nurse shall not sign any record attesting to the wastage of controlled substance medications unless the wastage was personally witnessed.
3. The licensed nurse shall not solicit the signatures on any record of a person as a witness to the wastage of controlled substance when that person did not witness the wastage.
4. The lost amount will be entered and deducted from the balance on the next unused line of the controlled substance administration record.
5. If this entry does not suffice as explanation, further details should be entered on the back of the form.
6. A damaged drug will be wasted by two nurses.
7. Both the nurses will sign and time the entry of the wasted medication.
8. When the size of a prescribed amount of drug necessitates the use of a partial ampule/medication, the whole number consumed will be entered in the dose column. In parentheses along-side of this entry, the actual amount given to the patient will be entered, and the quantity wasted will be noted and initialed.
9. Expired, discontinued controlled substance medications will be disposed of by two Licensed Nurses.
10. No licensed nurse will ever sign out and then delegate to another nurse to give a resident's medication or falsify nursing or CNA signatures.

Revised: 08/19

MEDICATION ERRORS/OMMISSIONS

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

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MEDICATION ERROR REPORT

Date of Report: _____
Resident Name: _____ Physician: _____
Room No. _____ Date of Error: _____ Time of Error: _____ A.M. _____ P.M. _____
Medication Given: _____ Dosage Given: _____ Rte. of Admin: _____
What was Physician's Order?

What was your source of information regarding the medication given? _____ Chart
_____ Medication Administration Record (MAR) _____ Verbal Order Other, list:

Explanation/reason medication error was made:

What was the actual effect of the error, if any, made on the resident?

How was the error discovered? _____
By Whom? _____ Date/Time: _____
Who notified the physician? _____ Date/Time: _____
Name of physician? _____
Has he/she seen resident since the error was made? _____ Were there any orders? _____
What precautions have been taken to prevent a similar error?

Date Pharmacist notified of error: _____
Pharmacy recommendations:

Signature of Nurse making error: _____ Date: _____

Director of Nursing Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Pharmacist Signature: _____ Date: _____

ADVERSE MEDICATION REACTIONS

Drug Allergies:

1. Allergies to medications will be noted on the profile page of the electronic medical record, the care plan, and the medication administration record.

Drug Interactions/Reactions:

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

2. The Director of Pharmacy, nursing staff, and physician are responsible for monitoring the possible interactions that may occur.
3. 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.
4. In the event that a drug intervention/reaction occurs, the licensed nurse assigned to resident shall stop the medication and notify MD and pharmacist for further instructions.

Drug Regimen Review

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

Reviewed: 08/19

MEDICATION REFRIGERATOR TEMPERATURES

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

Reviewed 09/19

STANDING ORDERS

When a Standing Order is used, a physician telephone order must be entered into the PCC and copied for physician signature. If a resident continues to require the medication or treatment for more than three days, 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 ALLERGY OR ALLERGIES.

1. Analgesic/Antipyretics:

- a. Acetaminophen tablet 500 mg give 1 tablet by mouth every 6 hours PRN minor aches and pains or temp greater than 101.0 F (oral or tympanic). Total acetaminophen dosage not to exceed 3000 mg/24-hour period.
- b. Acetaminophen suppository 650 mg insert 1 suppository rectally every 4 hours PRN minor aches/pains or temp greater than 101.0 F (oral or tympanic). Total acetaminophen dosage not to exceed 3000mg/24-hour period.
- c. Aspirin tablet 325 mg give 2 tablets by mouth every 6 hours PRN minor aches/pains or temp greater than 101.0 F (oral or tympanic) if **allergic** to or unable to take Tylenol.

2. Bowel Elimination:

- a. Docusate Sodium (Colace) tablet 100 mg give 2 tablets by mouth in the evening PRN Constipation.
- b. Senna (sennoside) tablet, 1 by mouth BID for constipation.

3. Cerumen:

- a. Debrox 2 drops PRN 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. Cough/Sore Throat/cold/sinus-nasal congestion:

- a. Guaifenesin syrup 10 ml by mouth Q 4 hours PRN cough times 3 days.
- b. Generic throat lozenge or equivalent cough drop, 1 lozenge by mouth up to 8 per day for cough time 3 days.
- c. Saline nasal spray 2 sprays each nostril every hour as needed for dryness/nasal congestion time three days.
- d. Mucinex 400 mg TID x 3 days.

5. Diarrhea:

- a. Imodium give 2 tablets by mouth every six hours PRN loose stools. If loose stools continue after 24 hours notify MD.

6. Dyspepsia:

- a. Calcium Carbonate 2 tabs by mouth every 2 hours PRN for gastric distress up to ten tablets per day.

7. Eye Irritation:

- a. Liquid tears instill 2 drops both eyes every 1-hour PRN for minor eye irritation/dryness.

8. Hypoglycemia: glucose get, glucagen, and finger stick blood glucose as appropriate – see blood sugar protocol for hypo/hyperglycemia.

9. Immunization/PPD:

- a. Influenza vaccine IM x 1 dose every fall, if no documentation for allergy to vaccine or eggs.
- b. Pneumovax vaccine IM x 1 dose on admission (if not previously documented) and 5 years later to fulfill their lifetime dose.
- c. PPD Mantoux skin test 5 units sub derma forearm, on day of admission, read within 48-72 hours.

10. Nausea/Vomiting:

- a. Zofran 4 mgSL every 6 hours as needed for nausea and or vomiting times 3 doses, contact MD if N/V continues.

11. Oxygen Saturation, decreased:

- a. Oxygen sat check Q shift
- b. Oxygen at 1 liter/min per NC continuously. If O₂ falls below 88% LN may increase O₂ up to 4L/min (using smallest amount possible). If sats cannot be maintained at or above 88% on 4L/min notify MD. Be aware of DX. I.E. COPD.

12. Post Foley Discontinuation:

- a. Bladder scan every 6 hours and following a void (PVR) times 3 days. Straight cath if >500 cc. Notify physician if scans >500 cc continue through the 3rd day.

13. Skin Tears/Draining Wound:

- a. Cleanse skin tear located _____ with normal saline approximate edges if possible, apply steri strip.
- b. Cover steri-strips located _____ with dry dressing and secure with tape or kerlex.
- c. Apply triple antibiotic ointment to wound, if draining and cover with appropriate dressing. Change every day and D/C when resolved.
- d. All other skin/wound problems need to be referred to resident's primary physician for appropriate orders (and communicated to RN Manager and skin/wound nurse).

14. Urinary Tract Infections:

- a. If signs and symptoms of a UA are present (strong odor, blood in urine, cloudy urine, increase frequency, c/o pain or burning with urination, fever, increased confusion) obtain a UA with C&S if indicated, send results to MD. If treated with ABO obtain an F/U UA after the ABO TX is completed by the physician.

EAR IRRIGATIONS

Ear irrigations may be performed by LN per MD order when necessary. 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.

Reviewed 08/19

INSTILLATION OF EYE DROPS

Wash hands before beginning, then apply gloves. Instill drops as directed, dropping medication onto conjunctiva surface of lower lid.

Record medication and time given.

Remove gloves wash hands before proceeding to next resident.

Application of Eye Ointment

Wash hands before beginning, apply gloves. Instill ointment onto conjunctiva surface of lower lid. Instruct resident to close eye and allow ointment to melt.

Record medication and time given.

Remove gloves wash hands before proceeding to next resident.

Reviewed 08/19

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.

Treatment:

Hypoglycemia

1. Observe the resident for signs and symptoms of hypoglycemia. Some common symptoms of hypoglycemia include sudden hunger; being shaky, weak, clammy, sweaty, flushed or hot; dizziness or headache; nausea; sudden personality change; or difficulty speaking or swallowing.
2. In the event that hypoglycemia is suspected, immediately obtain a finger stick blood glucose level.
3. If the resident's blood glucose is less than 80 mg/dl, follow the Hypoglycemia/Hypoglycemia protocol.
4. If a resident is NPO (enteral feeding) refer to clinician for resident specific hypoglycemia orders.

Hyperglycemia

1. Observe the resident for signs and symptoms of hyperglycemia. Some common symptoms of hyperglycemia include frequent urination, extreme thirst or dry mouth; sweet or fruity breath; tiredness or fatigue; increased hunger; blurred vision; nausea and vomiting; and stomach pains or cramps.
2. If the resident's blood glucose level is over 400 mg/dl, follow the Hyperglycemia/Hypoglycemia protocol.

Glucose Monitoring

1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines.
2. The physician will order the frequency of blood glucose monitoring.
3. Residents whose blood sugars are poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation.
4. "Finger sticks" (capillary blood samples) measure current blood glucose levels.
 - a. The reference ranges for normal blood glucose vary with different laboratories.

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- b. Normal ranges are approximately 90-130 mg/dl before meals and <180 mg/dl after meals.
 - c. Hyperglycemia is considered anything above target reference ranges.
 - d. Having hyperglycemia is not the same as having diabetes.
5. Approximate reference ranges for hypoglycemia are:
1. Mild hypoglycemia 55-80 mg/dl
 2. Moderate hypoglycemia 40-55 mg/dl
 3. Severe hypoglycemia <40 mg/dl
6. Hemoglobin A1C (glycosylated hemoglobin) is a blood test that measures the average blood glucose over time (two to three months) and therefore may be a better estimate of treatment efficacy than blood glucose readings.
7. Percentage of glycosylated hemoglobin should be <7% in a diabetic individual.
8. Measure ketones in urine as ordered, as a marker of the body's glucose utilization.

Management of Hypoglycemia and Hyperglycemia – See the Diabetes Management – Hypoglycemia/Hyperglycemia Protocol

Medication Management –

1. Insulin is required for individuals with Type I diabetes.
2. Insulin can be administered by a syringe, pump or pen.
3. Medication manage of Type II diabetes may include oral hypoglycemic agents with or without insulin.

Revised 08/19

HYPERGLYCEMIA/HYPOGLYCEMIA PROTOCOL

<p>If the residents blood glucose is less than 80 mg/dl, and the resident is awake and can swallow:</p>	<ol style="list-style-type: none"> 1. Give a fast-acting carbohydrate with 15-20 grams of glucose, such as 4 oz. orange juice or 5-6 oz. of soda. 2. Recheck the blood glucose in 15 minutes. 3. If the resident's blood glucose returns to normal (greater than 80 mg/dl), give a low-fat meal or snack and notify the clinician. 4. If the blood glucose remains less than 80 mg/dl, repeat treatment with a fast-acting carbohydrate with 15-20 grams of glucose, such as 4 oz. orange juice or 5-6 oz. of soda. Recheck the blood glucose in 15 minutes. 5. If the blood glucose remains less than 80 mg/dl (and the resident is responsive and able to swallow), administer Oral Glucose Paste to buccal mucosa, notify the clinician and follow the clinician's further instructions as applicable.
<p>If the residents blood glucose is less than 80 mg/dl, and the resident is unconscious or cannot swallow a carbohydrate supplement:</p>	<ol style="list-style-type: none"> 1. Give 1 mg Glucagon IM, notify the clinician and follow the clinician's further instructions, if applicable. 2. Recheck blood glucose in 15 minutes. 3. If the resident is responding, give a low-fat meal or snack and notify the clinician. 4. If the resident fails to respond, call 911 in accordance with the resident's advance directives. 5. Notify the clinician and responsible party. 6. Stay with the resident and monitor his or her vital signs.
<p>If a resident is NPO (enteral feeding)</p>	<ol style="list-style-type: none"> 1. Refer to clinician for resident specific hypoglycemia orders.
<p>If the resident has blood glucose levels over 400 mg/dl:</p>	<ol style="list-style-type: none"> 1. Immediately call clinician unless specific orders already in place. 2. Standing Orders: Administer 10 units Humalog, recheck Q 2 hours, administer 5 units Humalog until FSBS <300 mg/dl

Revised 08/19

TRANSCRIBING MEDICATION/TREATMENT ORDERS

Policy:

Medications and treatments ordered by a physician, including telephone orders, must be taken by a licensed nurse.

- Rehabilitation treatment orders can be written by a licensed physical therapist, speech therapist, and occupational therapist. If speech therapist is ordering a change of diet then this must be communicated to the dietary department. These orders are to have the same procedure followed as T.O. and V.O. orders.
- Consultation forms must be noted by a licensed nurse. These orders must also follow the procedure for transcribing T.O. and V.O.
- Physicians have up to 7 days to sign any and all orders received by the LN via telephone, verbal or standing order.

Procedure:

1. Receiving a written order:
 - a) Orders must be written by a physician.
 - b) Ensure the order is complete and includes resident name, date, time, diagnosis, route, dosage, frequency and physician signature.
 - c) The order is to be entered into the electronic medical record by LN or Ward Clerk (with LN noting order).
2. Receiving a telephone or verbal order:
 - a) Before terminating conversation with the physician repeat the order to clarify and ensure that the following necessary information is included: Medication, dosage, route of administration times and/or frequency of administration, number of days or doses, and reason (indication-dx.) for medication/treatment.
 - b) Immediately input to electronic medical record orders tab. You must include the date ordered and the time ordered.
 - c) Notify resident and/or family or guardian.
 - d) Make a complete nursing notation in the nursing progress notes as to the order obtained, why it was obtained, resident and/or family notified (give name of family member).
 - e) Update the resident care plan when indicated.
 - f) Communicate the new order by utilizing the 24-hour report or the communication book whichever is appropriate.
 - g) Place resident on alert charting.

Revised 08/19

MEDICATION ADMINISTRATION/PERIPHERALLY INSERTED CENTRAL CATHETER (PICC)

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

Procedure:

STEPS	KEY POINTS
1. Wash hands. Don gloves	1.1 Reduces transmission of micro-organisms. 1.2 Standard precautions.
2. Verify physician order for medication.	2.1 Reduces possibility of medication error.
3. Explain procedure to the patient/family. Outline the reason for the medication.	3.1 Decreases patient/family anxiety.
4. Open closure clamp on P.I.C.C. extension.	4.1 There may be a solid extension or a separate clear luer-lock extension tubing present.
5. Flush the P.I.C.C. with 5 ml of normal saline solution.	5.1 Clears the line of Heparin solution; checks patency of line.
6. Attach the intravenous (I.V.) set for piggyback medication or syringe for I.V. push medication and administer.	6.1 Inject over the recommended period of time to prevent any untoward effects of too rapid or too slow administration time.
7. Assess the patient during the medication administration as the resident's condition warrants.	7.1 Blood pressure, pulse, cardiac rhythm etc., may need to be assessed during administration of some vasoactive medications.
8. After administration, flush with 5ml of NaCl use the “push-pause” technique.	8.1 The technique creates turbulence within the lumen and assists in the removal of the medication.
9. If TPM, lipids or blood are being discontinued, flush with 20 ml of NaCl.	9.1 More flush solution is needed to thoroughly clear the lumen of the more viscous solutions.
10. If the P.I.C.C. is to be utilized as a locked (intermittent) device, flush with 2 ½ ml of Heparin 10 units/ml solution. Close the clamp pressure after the flush solutions are given.	10.1 Flush using the same push-pause technique. When withdrawing the needle, exert positive pressure on the end of the syringe plunger, and close the clamp on catheter. This prevents blood from being pulled back into the catheter lumen.
11. For multiple I.V. push/piggyback medications, or if medications are given with I.V. infusing through the P.I.C.C., flush with 5 ml NaCl between medications and at the end of the push/piggyback administration.	11.1 Prevents possible medication interaction with lumen. 11.2 Flush with Heparin solution at the END of the multiple injections.
12. Discard syringes and access cannulas in appropriate sharps disposal container.	12.1 Standard precautions.
13. Wash hands.	13.1 Prevents transmission of micro-organisms.
14. Document medication administration and flush solutions on resident's medication administration record (E-MAR).	14.1 Documents completion of order. Serves as a legal document. Notes patient response and outcome.

Reviewed 08/19

INTRAVENOUS MEDICATION ADMINISTRATION VIA NEEDLELESS ACCESS DEVICE (HEP-LOCK)

Standard:

An Intravenous (IV) catheter with venous needless access device is used to administer IV medications when continuous administration of fluids is not necessary.

Policy:

- Medication are administered via IV catheter with a venous needless access device by a physician or registered nurse.
- IV medications require an order from a physician that must be reviewed every seven days unless otherwise specified by a physician.
- The facility pharmacy is responsible for preparation and delivery of IV medications to the units.
- When the pharmacy is closed, the nursing supervisor or pharmacist on call is responsible for delivering IV medications to the nursing units.

Procedures:

1. Verify physician order and check medical record for allergies.
2. Assemble equipment.
3. Identify resident and check identification bracelet.
4. Explain procedure to resident. Provide privacy.
5. Wash hands before and after procedure. Wear gloves.
6. Prepare IV medication bottle or bag for administration, (IE: connect to IV tubing and prime tubing).
7. Cleanse access device with alcohol prep and insert syringe containing 3 cc normal saline solution. Gently instill the saline solution, observing for patency.
8. Remove and dispose of syringe.
9. Connect IV medication tubing to access device.
10. Adjust flow rate accordingly.
11. On completion of infusion of medication, unplug tubing from access device, and flush using a syringe containing 3 cc of normal saline solution or as ordered.
12. Leave medication bottle or bag and tubing until next medication administration. Tubings are labeled and changed every 24 hours, unless otherwise indicated.
13. Discard medication bottle or bag after infusion or every 24 hours, along with tubing.
14. Document in Medication Administration Record.
15. Document In clinical notes any problems, and notify physician of adverse reactions (i.e., allergic response, resident intolerance or signs of infection).
16. Update resident care plan, as applicable.

Revised 08/19

IX COMFORT CARE

COMFORT CARE, TERMINAL

Purpose:

Terminal comfort care provides supportive care for residents and their families during the end 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. 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 including hospice care if ordered by the physician.
3. Emphasis will be placed on the management of physical and psychosocial needs of the resident.
4. The resident care plan will be initiated/updated to define appropriate goals and interventions.
5. All treatments and interventions are representative of current standards of care.
6. 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, pain medications, etc.

Revised 08/19

POSTMORTEM PROTOCOL

In the event of a death of a resident the licensed nurse assigned the resident shall:

1. Immediately notify physician/provider. (Document discussion in nurse progress notes.)
2. Immediately notify family and/or responsible party as delineated in face sheet of medical record. (Document discussion in nurse progress notes.)
3. Notify mortuary identified in resident's record. (Document discussion in nurse progress notes.)
4. If the resident's death was UNEXPECTED immediately notify:
 - Director of Nursing Services
 - RN Manager
 - Social Services Director
 - Administrator

Reviewed 08/19

CELESTIAL DISCHARGE/POSTMORTEM CHARTING

Procedure: Licensed nurse will notify residents primary physician of assessment in the event a resident succumbs.

Assessment will include:

1. No apical pulse over one minute, no respirations, no BP, pupils unresponsive, time of assessment.
2. Notify family and MD.
3. Last cares, interactions, interventions provided.
4. Any patches, Foleys, etc. discontinued
5. Final skin assessment
6. Time of death
7. Who was notified, family, legal representative, etc.?
8. Order obtained written to release the body.
9. Time and Name of the mortuary called.
10. Time resident left the facility.
11. Licensed nurse will document on the 24-hour report and census clipboard.

Revised: 08/19

CERTIFIED NURSE AIDE POSTMORTEM CARE

1. Help with CPR if initiated.
2. If resident is determined to have died, ensure resident's privacy.
3. Wash body if soiled. Handle gently to prevent tissue trauma.
4. Place pad under resident.
5. Dress resident in gown open in the back.
6. Arrange in sleeping position.
7. Cover with clean blanket or sheet as if asleep, do not cover face.
8. Box and label personal possessions keeping aside small keepsakes, valuables, money, wallet, glasses. Bag and place valuables in med room.
9. Determine if teeth and glasses should be sent with the resident. If so, place on bed under cover by shoulder.
10. Assist with mortician as requested to transfer body to gurney.
11. If other residents ask if someone has died, you may answer with a simple correct response such as "Yes, John has just died." Give no other personal or medical details.

Revised 08/19

X INFECTION CONTROL

INFECTION PREVENTIONIST

Purpose:

The purpose of the preventionist is to establish and maintain an infection control and prevention program designed to prevent the development and transmission of communicable diseases and infections.

Procedure:

1. The facility will designate a qualified individual (Professional licensed nurse or certified professional who is certified an infection control and prevention services) as Infection Preventionist (also known as IP, an individual or individuals designated by the facility to be responsible for the infection prevention and control program). Their primary role is to coordinate and be actively accountable for the facility's Infection Prevention and Control Program.
2. The Infection Preventionist must be adequately qualified and must meet the following eligibility requirements:
 - a. Current license in the state of Idaho
 - b. Primary professional training in nursing, medical terminology, microbiology and epidemiology.
 - c. Education, Training, experience or certification in infection control and prevention.
 - d. Completed specialized training in infection prevention and control through an accredited continuing education program.
 - e. Works for the facility at least part time.
3. The Infection Preventionist works directly with the Director of Nursing.
4. The responsibilities of the Infection Preventionist include but are not limited to:
 - a. Development and Implementation of ongoing infection prevention and control programs to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment.
 - b. Establish facility wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff and visitors.
 - c. Develop and implement written procedures in accordance with CMS standards of practice and recognized guidelines for infection prevention and control.
 - d. An antibiotic Stewardship program.
 - e. Oversee the resident care activities (use and care of urinary catheters, wound care, incontinence care, skin care, performing finger sticks, medication administration, etc.)
 - f. Review and/or revise the facility's Infection Prevention and Control program, its standards, policies and procedures annually as needed for changes to the facility assessment to ensure they are effective and in accordance with the current standards of practice for preventing and controlling infections.

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5. The Infection Preventionist will participate in the Quality Assessment and Assurance Committee (QAA) and will report regularly on the Infection Prevention and Control Program activities.

Reviewed 12/19

ANTIBIOTIC STEWARDSHIP PROGRAM

Purpose:

The purpose of this program is to reduce inappropriate use of antibiotics, improve resident outcomes.

Procedure: The Antibiotic Stewardship program is part of our Infection Control Program. The facility will:

1. Track antibiotic use daily.
2. Monitor cultures for correct use of antibiotics.
3. Communicate with the physicians prescribing antibiotics with an "antibiotic report card" on a quarterly basis.
4. Educate all nurses on hire and as needed regarding proper assessment for infection prior to calling the physician using the McGreer criteria.
5. Ensure the pharmacy reviews all antibiotic usage for appropriateness.
6. Calculate antibiotic use on a monthly basis for purpose of QAPI.
7. Monitor for all adverse reactions/outcomes related to antibiotic therapy.
8. Involve the laboratory in our QAPI meetings as applicable.
9. Request the antibiogram from the pathology laboratory at least yearly.
10. Provide ongoing inservices to the nursing department in regard to antibiotic stewardship, McGreer criteria, and needs for documentation.

Reviewed 12/19

INFECTION CONTROL COMMITTEE

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

- Infection Prevention Nurse (Chair)
- Medical Director
- DNS
- Administrator
- Pharmacist
- Dietary Services Supervisor
- Housekeeping (management represent)
- Maintenance Supervisor

This committee will be responsible for the development and implementation of infection control policies and procedures including the designation of a facility employee(s) to monitor practices within the facility. This committee will meet as a group no less often than quarterly to review areas of concern. Documentation of said meetings will be maintained showing members present, business addressed and signed and dated by all members of the committee.

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.

Infection control rates will be presented and discussed at each infection control committee meeting.

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

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

Reviewed 12/19

INFECTION CONTROL SURVEILLANCE

Purpose:

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

Procedure:

11. 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) Personal consultation by employees.
 - e) Follow-up on communicable disease exposure.
 - f) Medical Director Consultation.
 - g) Review of geographic location of infections for potential problems/trends/outbreaks.
12. 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.
13. Report infections to the District Health Department, as required.

Reviewed 12/19

TUBERCULOSIS CONTROL PLAN

Employees

All employees shall be screened for presence of infection with M. Tuberculosis using the Mantoux PPD skin test.

1. Employees with a negative PPD skin test history shall obtain a PPD skin test within thirty days of employment (or present proof of negative PPD status within the last year).
 - a) Employees in need of a current (within one year) PPD skin test shall utilize the form in their orientation packet.
 - b) Employees may obtain the PPD skin test from the Infection Control nurse or a licensed nurse.
 - c) Employees obtaining the PPD skin test must have the test read by a licensed nurse and results documented on the appropriate form within 72 hours of testing.
 - d) Employees will then submit the completed form to the facility's Human Resource Department or designated representative for tracking and follow-up, as needed.
2. For purposes of interpretation, a skin test reaction of > 10mm. induration is generally considered positive.
 - a) A person with a positive PPD (> 10 mm.) shall be referred either to their private physician or to the Public Health Department for follow-up and/or treatment.
 - b) A letter from a physician or health department attesting to the non-infectious nature of the employee and must be received within one week of positive PPD result.
3. Employees with a documented history of a positive PPD will not undergo skin testing. Employees will, however, complete the Tuberculosis Assessment form and return to the facility's Infection Control Nurse or designated representative for further processing.
4. Employees who are medically exempt from receiving a PPD skin test (e.g. pregnancy) must submit a letter to the Human Resource Department from a physician attesting to the exempt status. When/if the medical condition allows testing, the above procedure shall be instituted.

Residents - Tuberculosis

1. Residents shall be screened for infection with M. Tuberculosis on admission.
 - a) PPD testing shall consist of a Mantoux skin test using 5 units of PPD injected intracutaneously.
 - b) Residents with a history of a positive skin test shall be screened by a chest x-ray and a physician's clinical assessment documented in the admission progress notes.
 - c) Skin testing for new admissions will employ the two-step procedure.

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

- i. If the reaction to the initial PPD test is < 10 mm., a second test will be given 7-14 days later.
 - 1) A positive second test is indicative of a boosted reaction and NOT a new infection.

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- 2) If the second test remains negative, the person is classified as uninfected.
 - ii. For purposes of interpretation, a skin test reaction of > 10 mm. induration is generally considered positive.
2. The results of all skin tests will be documented on the 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. D. 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.

Reviewed 12/19

TUBERCULOSIS EXPOSURE INCIDENT

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

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

Reviewed 12/19

TUBERCULOSIS (PPD) TESTING – EMPLOYEE / VOLUNTEER

Name _____

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

Please indicate one of the following:

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

Reviewed 12/19

TUBERCULOSIS ASSESSMENT

(For use with staff who are PPD positive or medically exempt upon hire and annually thereafter)

Please complete the following brief questionnaire about your health:

Do you currently have any of the following symptoms?

- 1. Cough lasting greater than 2 weeks? ___yes ___no
- 2. Unexplained weight loss? ___yes ___no
- 3. Loss of appetite? ___yes ___no
- 4. Unexplained fever? ___yes ___no
- 5. Night sweats? ___yes ___no
- 6. Blood tinged sputum production? ___yes ___no

If yes to any question, please describe symptoms further. When did this start? Have you sought treatment? If yes, what treatment was done?

Employee signature _____ Date _____

Infection Control/Employee Health Nurse _____ Date _____

FOR OFFICE USE ONLY

Was this employee referred for further evaluation? ___ yes ___ no

If yes, to whom?

Chest x-ray? _____ Medication? _____ Work restrictions? _____

Infection Control/Employee Health Nurse _____ Date _____

Reviewed 12/19

HEPATITIS B IMMUNIZATION PROGRAM

Purpose:

To establish guidelines for employee screening for Hepatitis B immunity and vaccine administration.

1. Employees who perform tasks requiring exposure to blood and other potentially infectious materials per exposure determination will be offered the Hepatitis B Vaccine free of cost.
2. Following a review of the disease and vaccine information, the employee will sign a consent to receive the vaccine. (See “Information on Hepatitis B and the Vaccine.”)
3. If an employee declines immunization, he/she will sign a waiver. If the employee chooses to be immunized in the future, this procedure will be followed.
4. Three IM doses of vaccine will be given - the initial dose, at one month and at six months. The vaccine will be administered deep intra-muscular in the deltoid muscle.

Reviewed 12/19

INFORMATION ON HEPATITIS B AND THE VACCINE THE DISEASE

The Disease

Hepatitis B is a viral infection that affects the liver. The incubation period ranges from 40 to 180 days. The course of acute hepatitis can be mild and completely without outward symptoms, or it can be severe, prolonged, and possible fatal. Health care workers can be exposed to Hepatitis B from contaminated needle punctures or blood spills on broken skin or mucous membranes. Other body fluids, such as bloody urine, bloody wound drainage, or semen, may also be infectious. The greatest threat to health care workers is the nearly one million Hepatitis B carriers in the country, 80 to 90 percent of whom are not identified.

Recombinant Hepatitis B Vaccine

The vaccine is for protection against Hepatitis B. The vaccine is recommended for those with frequent exposure to the above sources. Three doses of vaccine are required: The initial dose, a second dose a month later and a third dose five months later. A booster dose may be needed at a later time for continued protection. Documentation of exposure incidents must continue even after the vaccine series is completed.

Hepatitis B vaccine will not prevent hepatitis caused by other agents, such as Hepatitis A virus, non-A, non-B Hepatitis virus or by other viruses known to infect the Liver. Although information available to date indicates that the vaccine is highly effective in protecting against Hepatitis B, it has not proven totally effective in preventing Hepatitis B among all persons vaccinated (those who are immune-suppressed or those with presence of any serious active infection). Hepatitis B vaccine is prepared from recombinant yeast cultures and is free of association with human blood or blood products.

Follow-up studies indicate that the most common side effect is injection site soreness. Less common local reactions are redness, swelling, and warmth, which usually subside within 48 hours. Low-grade fever occurs occasionally. Other complaints include malaise, fatigue, headache, nausea, dizziness and joint pain. These symptoms are infrequent and limited to the first few days following the vaccine. Rash has been reported rarely.

Precautions

Recombinant Hepatitis B Vaccine is contraindicated for individuals who are hypersensitive to yeast or any component of the vaccine. Any serious active infection prior to receipt of the vaccine is reason to delay the vaccine.

Employees with a history of cardiopulmonary disease are at risk from a possible febrile or systemic reaction and must consult their private physicians prior to receipt of the vaccine and have an authorization from their private physician for administration of the vaccine.

Reviewed 12/19

HEPATITIS B VACCINATION OFFER

- I understand that I am offered the HBV vaccine at no charge to myself and will obtain the series of vaccines at the nursing station where I am assigned.
- I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring Hepatitis B virus (HBV) infection. I am offered the opportunity to be vaccinated against HBV at no charge, however, I decline the HBV vaccination at this time.
- I understand that by declining this vaccine, I continue to be risk for acquiring HBV. If in the future I continue to have occupational exposure and I want to be vaccinated with HBV vaccine, I can receive the series at no charge.
- I understand I am offered the HBV vaccine at no charge to myself, however I decline due to the fact that I have received the series at another facility.
- I understand that if I received a partial series, I may finish the series at no charge.

Employee Signature

Date

Employee's SSN

Reviewed 12/19

HANDLING AND/OR DISPOSING OF USED NEEDLES

Purpose:

To provide guidelines for the safe handling and disposal of used needles.

1. Equipment And Supplies
 - a) Sharps container,
 - b) Gloves (as indicated); and
 - c) Other as necessary or appropriate.

2. Safety Precautions
 - a) After use, discard the needle without recapping into the sharps container.
 - b) If recapping is absolutely indicated, and the sharps container is not readily available, the cap should be reapplied using one of the following methods before leaving the point of use:
 - i. Use a needle-recapping device (e.g. stationary cap-holding device); or
 - ii. Place the cap on a horizontal surface and use the one-hand scoop method to slide the needle into the cap.
 - c) Used needles must be placed in the sharps container. Do not bend, break, or cut needles. When the sharps container is 75% to 80% filled, the container must be stored until picked up by housekeeping for proper disposal.
 - d) Needles, used or unused, may not be discarded into trash receptacles.
 - e) In the event of a needle stick injury, the employee should:
 - i. **Immediately** wash the wound with soap and running water;
 - ii. Cause the injured site to bleed;
 - iii. If desired, apply alcohol or hydrogen peroxide to the wound; and
 - iv. Notify the infection control coordinator of the incident as soon as practical.
 - f) Refer to procedure “Protocol for Exposure to Blood Borne Pathogens.”

Reviewed 12/19

HAND HYGIENE

Standard:

The following is an important part of Standard Precautions. Hand hygiene should occur prior to and following the delivery of personal cares, administration of medications and treatment, and other nursing interventions.

Policy:

All personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure, after sneezing or blowing nose, after using the toilet, before handling food, and when hands become obviously soiled.

Alcohol Based Hand Rub (ABHR) may be used unless:

1. Potential or Actual contact with bodily fluids.
2. If hands are visibly soiled

Procedure:

1. Stand in front of sink, keeping hands and uniform away from sink surface (if hands touch sink during procedure start over).
2. Turn on water, regulate the flow and temperature, water should be warm.
3. Avoid splashing water against uniform.
4. Wet hands and wrists thoroughly under running water.
5. Keep hands and forearms lower than elbows during washing.
6. Apply a small amount of soap or antiseptic, lathering thoroughly.
7. Wash hands using plenty of lather and friction for at least 20 seconds.
8. Interlace fingers and rub palms and back of hand with circular motion at least 5 times each. Keep fingertips down to facilitate removal of microorganisms.
9. Areas underlying fingernails are often soiled. Clean them with fingernails of other hand if heavily soiled.
10. Rinse hands and wrists thoroughly, keeping hands down and elbows up.
11. Dry hands thoroughly from fingers to wrists and forearms with paper towel, discard.
12. Turn off water using the clean paper towel.
13. Discard paper towel.
14. If hands are dry or chapped may apply a small amount of lotion or barrier cream.

Updated 5/21/2020

USING GLOVES

Purpose:

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

1. Equipment And Supplies
 - b. Gloves
 - c. When gloves are indicated, disposable single-use gloves should be worn.
 - d. Used gloves should be discarded into the waste receptacle inside the room.
 - e. Sterile gloves should be used only in performing sterile procedures (e.g. Foley insertion).
 - f. Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces.
 - g. Wash hands after removing gloves. Gloves do not replace hand washing.
 - h. Disposable (single-use) gloves must be replaced as soon as practical when contaminated or as soon as feasible if they are torn or punctured and when they exhibit signs of deterioration or when their ability to function as a barrier is compromised.
2. When To Use Gloves:
 - a) a. Gloves should be used:
 - i. When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin;
 - ii. When the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc.;
 - iii. When cleaning up spills or splashes of blood on body;
 - iv. When handling potentially contaminated items;
 - v. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material;
 - vi. 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.
 - b. Removing gloves:
 - i. Using one hand, pull the cuff down over the opposite hand turning the glove inside out.

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- 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 08/19

**PROTOCOL FOR EXPOSURE TO BLOOD BORNE PATHOGENS
(NEEDLE STICKS)**

All needle sticks require reporting and completion of an incident report to the Director of Nursing Services.

1. Testing for blood borne pathogens will be done at the time of the stick, and at three (3), six (6), and twelve (12) month intervals. (if indicated)
 - a) Affected employee will be sent to Valley Medical Clinic for blood draw and follow up labs.
 - b) Lab result records will be maintained in the specific employee's medical file.
2. Affected employee will be informed regarding recommendations for Hepatitis B prophylaxis.
3. 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.
 - c) 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.
 - d) If resident has been in facility less than 5 years, licensed nursing staff shall:
 - i. Obtain order for lab testing for HIV/Hepatitis B.
 - ii. Notify family/responsible party regarding proposed interventions.

Reviewed 08/19

**RECOMMENDATIONS FOR HEPATITIS B PROPHYLAXIS
FOLLOWING PERCUTANEOUS OR PERMUCOSAL EXPOSURE**

Exposed Person	HBsAg Positive	HBsAg Negative	Source not tested or unknown
Unvaccinated	HBIG X 1* and initiate HB vaccine series	Initiate HB vaccine series	Initiate HB vaccine series
Vaccinated:			
Known responder	No treatment	No treatment	No treatment
Known non-responder	HBIG X 2 or HBIG X 1 and initiate	No treatment	High risk source may treat as if revaccination.
Vaccinated:			
Response unknown	Test exposed for anti-HB's	No treatment	Test exposed for anti-HB's
	1. If adequate, no treatment.		If adequate, no treatment.
	2. If inadequate, ** HBIG x 1 plus one HB vaccine booster dose.		If inadequate, initiate revaccination series.

Hepatitis B Immune Globulin (0.6 ml/kg IM)

** Adequate anti- HB's is ≥ 10 mIU/ml

Reviewed 08/19

BLOOD SPILL KITS

Blood Spill Kits will be available in the non-chargeable room. Each Blood Spill Kit contains specific items needed to comply with OSHA Blood Borne Pathogen Regulations. (i.e. gloves, face mask, isolyser powder, plastic scoop, Bio-hazard disposable bag and instruction sheet.)

If a large volume blood spill occurs (nose bleed, GI bleed) obtain a kit from the non-chargeable room. Don an apron or disposable gown, an eye shield/face mask and gloves. Sprinkle the isolyser onto blood spill, allow to congeal, 5 to 10 minutes. Use the plastic scoop to pick up the solidified liquid and dispose of properly by placing in the Bio-hazard bag, seal with tie-band and place in the Bio-hazard trash.

Report process to licensed Nurse, RN Manager, and request replacement kit for unit.

Reviewed 12/19

EMESIS IN THE DINING ROOM

Purpose:

It is the policy of this home that any resident experiencing vomiting in the dining room shall be able to maintain his/her dignity while nursing takes care of the situation using universal precautions. The resident that has a history of vomiting in the dining room will always be served meals on the same type of dishes as the other residents.

Main Dining Room:

If a resident experiences vomiting in the dining room, the nurse in charge will direct someone to take the resident out of the dining room. There are blue vomit bags under the hand washing sink.

Notify kitchen and obtain a bus tub with a standard sanitizing solution from the kitchen staff. Place shirt protectors and washcloths in a bio-hazard bag. Bio-hazard bags can be obtained from under the hand washing sink. Tie the bag shut and put in laundry hamper with other shirt protectors. The red bag will alert laundry staff of the situation. Dump all food, vomit, liquids into a new red bio-hazard bag. Tie shut and place in garbage can in the dining room.

Place all empty dishes into the bus tub and wheel tub to the janitor's closet off the dining room. Kitchen staff will take care of the bucket after the dining room is clear of all residents.

North Dining Area:

If a resident experiences vomiting in the dining room, the nurse in charge will direct someone to take the resident out of the dining room. There are blue vomit bags in the upper cupboard by hand washing sink.

Notify kitchen and obtain a bus tub with a standard sanitizing solution from the kitchen staff. Place shirt protectors and washcloths in a bio-hazard bag. Bio-hazard bags can be obtained from the upper cupboard by hand/sink. Tie the bag shut and put in laundry hamper with other shirt protectors. The red bag will alert laundry staff of the situation. Dump all food, vomit, liquids into a new red bio-hazard bag. Tie shut and place in garbage can in the dining room.

Place all empty dishes into the bus tub and wheel tub to the janitor's closet off the North hall. Kitchen staff will take care of the bucket after the dining room is clear of all residents.

Kitchen Staff: Retrieve bus tub from the Janitor's closet and run dishes through the dishwasher AFTER all other dishes have been washed, and the water has been changed in the dishwasher. When done, drain dishwasher again and refill.

Reviewed 08/19

STANDARD PRECAUTIONS

Purpose:

It is the intent of this facility that:

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

Barriers Indicated In Standard Precautions

1. Gloves should be worn whenever exposure to the following is planned or anticipated
 - a) Blood/blood products/body fluids with visible blood
 - b) Urine
 - c) Feces
 - d) Saliva
 - e) Mucous membranes
 - f) Wound drainage
 - g) Drainage tubes
 - h) Non-intact skin
 - i) Amniotic, cerebral spinal, pericardial, pleural, peritoneal, synovial fluids
 - j) Performing venipuncture or invasive procedures
2. Masks 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. Eyewear; protection over the eyes should be worn during procedures that are likely to generate droplets of blood/body fluids.
5. Private Room; consider when resident hygiene is poor or in cases where blood/body fluids cannot be contained.
6. Hand washing refer to procedure on hand washing.
7. Trash/Linens will be bagged prior to leaving the residents' room.

Reviewed 08/19

PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. PPE is provided to all associates. Each associate is responsible for knowing where the equipment is kept in the department.
2. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. PPE available includes gloves, gowns or aprons, masks, eye protection, and resuscitation devices.

Reviewed 08/19

CONTACT PRECAUTIONS

Purpose:

It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct patient 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

Barriers Indicated For Contact Precautions

Resident Placement

1. Resident may be placed in a private room. If a private room is not needed/not available, the resident may be placed in a room with a resident(s) who has active infection with the same organism but with no other infection.
2. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement.

Gloves and Hand Washing

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.
3. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces.

Patient Transport

1. Activities of the resident may need to be limited.
2. If the resident leaves the room, precautions should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.

Patient Care Equipment

1. Dedicated patient-care equipment 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.

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Contact Precautions May Be Considered For (Examples):

- Multi-resistant organisms (e.g. non-pulmonary MRSA, VRE)
- Scabies
- Clostridium difficile

Reviewed 08/19

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.

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 residents coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning, aerosolized procedure.

Resident Placement:

1. Resident may be placed in a private room. If a private room is not necessary/not available, the resident may be placed in a room with a resident(s) who has an active infection with the same organism but with no other infection (cohorting).
2. When a private room is not available and cohorting is not an option, maintain spatial separation of at least 6 feet between the infected resident and other residents and visitors.
3. Special air handling and ventilation are not necessary, door must remain closed.

PPE:

1. A surgical mask (if available) and eye protection must be worn when in the room.
2. PPE – gown and gloves must be worn in the room.
3. N95 or higher mask and eye protection/face shield to be worn to perform aerosolized procedures.

Transport

1. Limit the movement and transport of the resident. If transport is necessary, place mask and gown on the resident to minimize dispersal of droplets.

Droplet Precautions May Be Considered For (Examples):

- Influenza
- Mycoplasma pneumonia
- Strep pharyngitis or pneumonia
- Pulmonary MRSA
- Covid-19

Reviewed 06/20

ADMISSION GUIDELINES

The following are admission guidelines:

1. Prior to admission, determine if the resident has infection or colonization of MRSA.
Note: If the resident has an infection with MRSA, admission should be delayed until there is evidence that colonization has occurred, or the infection has been eradicated.
 - Colonization is determined by the absence of clinical signs and symptoms of infection 48 hours after the completion of antibiotic, but with a positive culture for MRSA
 - If colonization has occurred, the admission committee will review the information to determine the facilities ability to accommodate the resident. This may be determined by meeting the criteria below for a resident colonized with MRSA.
 - Eradication of MRSA is determined by two consecutive negative cultures obtained 24 hours apart. Cultures are to be obtained from the nares, inguinal areas, sputum and urine. (Eradication of MRSA is not routinely attempted in the long-term health care setting due to its marginal success rate and prevalence for the recurrence of MRSA in the absence of ongoing surveillance.

Guidelines for Residents Colonized With MRSA

The following are general guidelines for residents with colonized MRSA:

- The ideal room placement is a private room or a room with other colonized residents.
- The MRSA colonized resident can share a room with a non-MRSA colonized resident who has no invasive sites (i.e. Foley catheter, wound(s), NG tube, etc.).
- Do not place a colonized resident with other residents who are:
 - o Severely immune compromised
 - o Severely debilitated
- Wear gloves when providing resident care.
- Wear gowns only if soiling with drainage or secretions is likely.
- Wear masks when in close contact with residents who have respiratory infections.
- Wear face shield/goggles when emptying urinary catheter bags isolation.

Reviewed 08/19

GUIDELINES FOR RESIDENTS WITH MRSA INFECTION

General Recommendations for Long-Term Care Facilities

The following are general guidelines for residents with MRSA infections:

1. Following documented lab findings of MRSA:
 - Notify the attending physician immediately and obtain orders for treatment and for contact precautions.
 - Update the resident care plan and CNA flow sheets with Isolation precautions. Place sign on door of resident's room to notify staff/visitors of the precautions needed before entering the room.
 - When possible and/or appropriate, place the resident in a private room or with another resident who has colonized MRSA or one who has no invasive sites or wounds.
 - Follow instructions in disease specific isolation precautions for multi-drug resistant organisms or place on contact isolation.

Maintain contact isolation until:

1. Forty-eight hours after a course of antibiotic treatment and signs and symptoms have ceased.
2. Two negative Staphylococcus Aureus cultures have been obtained at least 24 hours apart; and
3. The Director of Nursing or the infection Control Nurse has reviewed and approve discontinuing the isolation or contact precautions.

Discontinuation of Contact Precautions.

- A patient with MRSA may be taken off Contact Precautions after two sets of cultures taken 24 hours apart are found to be negative for MRSA. These cultures should be taken from each previously infected or colonized site and from the anterior nares. These cultures should be taken at least 48 hours after all antibiotics have been discontinued.
- If results of culture indicate colonized MRSA, then follow steps for management of colonized residents.
- Decolonization or Eradication regimens are not sufficiently effective to warrant routine use. Therefore, most healthcare facilities have limited the use of decolonization to MRSA outbreaks, or other high prevalence situations, especially those affecting special care units. (Management of MDRO in HealthCare Settings, 2006).

Reviewed 08/19

METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Purpose:

To promote an environment conducive to controlling the spread of Methicillin Resistant Staphylococcus Aureus (MRSA) to the extent possible by appropriate management of any resident in the facility with MRSA and in accordance with acceptable CDC guidelines.

Procedure:

In caring for residents with MRSA, the following precautions will be observed.

1. Hand Washing
Thorough hand washing will be done before/after and pm while caring for the resident.
2. Room Arrangements
It is preferable for residents with MRSA to be cohorted (share a room or be in a specific area with MRSA residents). A private room may be needed in special circumstances, e.g. copious drainage that cannot be contained by a dressing or a respiratory infection caused by MRSA. Confinement to the room will depend on the resident's condition, personal hygiene and ability to comply with instructions.
3. Masks
Masks may be needed for close contact with residents if MRSA is in the respiratory tract and the resident is coughing.
4. Gowns or Aprons
Gown or aprons are indicated if it is likely that the clothing will be soiled with the infectious material (e.g. sputum, wound drainage, urine).
5. Gloves
Gloves should be worn when touching the infectious material is anticipated.
6. Trash And Linens
Trash and linen will be handled in the same manner as all trash and linen in the facility.
7. Standard Precautions
Standard Precautions are used in the care of all residents. This policy does not change the need for caution in touching all blood and body fluids.
8. Surveillance Cultures
In some circumstances, the Infection Control Committee may choose to do surveillance cultures of residents or personnel, this may include nares, axilla, and groin. Surveillance cultures for MRSA are not routinely done.

Reviewed 08/19

MRSA RECOMMENDATIONS
GENERAL RECOMMENDATIONS FOR LONG-TERM CARE FACILITIES

The following general infection control measures are appropriate for preventing spread of MRSA:

1. Procedure Recommendations:
 - a. Inform all employees about resistant organisms and how to deal with them.
 - b. Observe universal/standard precautions at all times. It is not practical nor possible to know all persons colonized or infected with MRSA or other resistant organisms.
These precautions must include:
 - i. Washing hands before and after contact with residents and pm. An antimicrobial hand soap may be useful when dealing with MRSA contamination.
 - ii. Wearing gloves when at risk for exposure to contact with any bodily substances and using proper hand washing techniques.
 - iii. Wearing a mask when in close contact with a resident who is coughing.
 - iv. Wearing a water-repellent gown to protect clothes when soiling with blood or body fluids is a possibility.
 - v. Cleaning the resident's environment (horizontal surfaces, etc.) daily and when visibly soiled.
 - vi. Disinfecting resident equipment (blood pressure cuffs, stethoscopes, etc.) between residents. Do not share resident personal items if MRSA is not contained.
2. Policy Recommendations
 - a) Colonization with resistant organisms such as MRSA is neither an indication for hospitalization nor a reason to restrict admission to a long-term care facility.
 - b) Isolation of residents colonized with resistant organisms such as MR.SA is not indicated under most circumstances.
 - c) Infections with resistant organisms such as MRSA should be evaluated and treated on a case-by-case basis.

Reviewed 08/19

MRSA / VRE RECOMMENDATIONS

Infection Control Recommendations for Long-Term Care Facilities

Note: The presence of wounds or other infected or colonized sites should not limit procedures such as physical therapy or compromise the level of resident care.

1. Residents with draining lesions at any site:
 - a) Cover draining lesions when possible.
 - b) Discard soiled dressings in leak-proof bag(s).
 - c) Bag all linen. Place wet or damp linen in leak-proof bag(s) for transport.
 - d) Wear gloves when manipulating the drainage area. Wash hands before and after gloving.
 - e) Wear water-repellent gowns when soiling of clothes is likely. Remove the gown before leaving the resident's room.

2. Residents with urinary catheters:
 - a) Change indwelling urinary catheters only when necessary.
 - b) Maintain a closed drainage system.
 - c) Keep drainage bags off the floor, but below the level of the resident's bladder.
 - d) Use a separate container for collection of urine from each resident. Avoid touching the container with the catheter bag or drainage spout.
 - e) Wash and thoroughly dry the resident's perineal area a minimum of once per shift or anytime it becomes soiled.
 - f) Secure the catheter to the resident to avoid tension on the urinary catheter.
 - g) Wash hands after manipulating the catheter or collecting urine.

3. Residents with respiratory symptoms:
 - a) Teach the resident to cough into a tissue and provide a bag for its disposal. Encourage resident to wash hands frequently.
 - b) Wear gloves when providing tracheostomy care, suctioning or giving mouth care.
 - c) Wear masks when in close contact with a resident who is coughing (e.g., when suctioning or giving mouth/tracheostomy care).
 - d) Wash hands after removing gloves.

Reviewed 08/19

CLOSTRIDIUM DIFFICILE

Policy Statement:

Preventative measures will be taken to prevent the occurrence of Clostridium difficile infections among residents and precautions will be taken while caring for residents with C. difficile (to prevent transmission of C. difficile to others).

Policy Interpretation and Implementation:

1. Suspected infections with Clostridium difficile will be verified by evidence of positive cytotoxin assay.
 - a) Testing will be performed on unformed stool only, unless ileus is suspected.
 - b) Testing of asymptomatic residents will not be done routinely.
2. Residents with diarrhea associated with C. difficile (i.e. residents who are colonized and symptomatic) will be placed on Contact Precautions for the duration of the illness. Healthcare workers and visitors will don gloves and gowns when entering the room of a resident with C. difficile infection.
 - a) Residents who are colonized with C. difficile but are asymptomatic do not require Contact Precautions.
 - b) Residents who are asymptomatic (diarrhea free) for 48 hours can be removed from precautions.
 - c) Residents with C. difficile infection will be placed in a private room if available. If a private room is not available, residents will be cohorted with a dedicated commode for each resident.
3. When caring for residents with diarrhea or fecal incontinence caused by C. difficile, staff will remain vigilant hand washing with soap and water, rather than alcohol-based hand rubs, for the mechanical removal of C. difficile spores from hands.
4. Residents considered at high risk of developing symptoms associated with C. difficile include those with:
 - a) Advancing age
 - b) Gastrointestinal manipulation (especially nasogastric tube insertion)
 - c) Previous gastrointestinal illness caused by C. difficile; and
 - d) Antibiotic or anti-neoplastic therapy.When residents with these risks have symptoms of diarrhea (i.e. three (3) loose stools in a twenty-four-hour period), C. difficile should be considered as a cause.
5. Clostridium difficile associated diarrhea is usually related to the use of antibiotics. Antimicrobial review and stewardship programs may decrease the potential for antibiotic related colitis.
6. Due to the persistence of C. difficile spores for prolonged periods of time, the environment shall be disinfected with a disinfecting agent recommended for C. difficile (e.g. household bleach and water solution or an EPA registered germicidal agent effective against C. difficile spores).
7. Steps toward prevention and early interventions include:
 - a) Increasing awareness of risk factors for the residents;
 - b) Considering C. difficile in differential diagnosis, especially in residents with high risk factors.

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- c) Hand washing by staff and residents;
 - d) Wearing gloves when handling feces or fecally contaminated articles;
 - e) Increased attention and education regarding infection control techniques when providing tube feedings;
 - f) Disinfection of items with fecal soiling (e.g. bed pans, commode chairs, bedrails, etc.) using a disinfectant agent recommended for *C. difficile* (e.g., household bleach and water solution or an EPA registered germicidal agent effective against *C. difficile* spores); and
 - g) Removal of environmental sources of *C. difficile* (i.e., replacement of electronic rectal thermometers with disposables).
8. Appropriate surveillance information must be entered on the *C. difficile* Line Listing Report.
9. Any resident with diarrhea shall be assessed for dehydration regularly.

Reviewed 08/19

VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)

Purpose:

To promote an environment conducive to controlling the spread of Vancomycin Resistant Enterococcus (VRE) to the extent possible by appropriate management of any resident in the facility with VRE and in accordance with acceptable CDC guidelines.

Procedure:

In caring for residents with VRE, the following precautions will be observed:

1. Hand Washing
Thorough hand washing will be done before/after and pm while caring for the resident.
2. Room Arrangements
It is preferable for residents with VRE to be cohorted (share a room or be in a specific area with VRE residents). A private room may be needed in special circumstances, e.g., copious drainage that cannot be contained by a dressing or a respiratory infection caused by VRE. Confinement to the room will depend on the resident's condition, personal hygiene and ability to comply with instructions.
3. Masks
Masks may be needed for close contact with residents if VRE is in the respiratory tract and the resident is coughing.
4. Gowns or Aprons
Gowns or aprons are indicated if it is likely that the clothing will be soiled with infectious material (e.g. sputum, wound drainage, urine).
5. Gloves
Gloves should be worn when touching the infectious material is anticipated.
6. Trash/Linens
Trash and linen will be handled in the same manner as all trash and linen in the facility.
7. Standard Precautions
Standard precautions are used in the care of all residents. This policy does not change the need for caution in touching all blood and body fluids.
8. Surveillance Cultures
In some circumstances, the Infection control Committee may choose to do surveillance cultures of residents or personnel (nares, axilla, and groin). Surveillance cultures for VRE are not routinely done.

Reviewed 08/19

VRE RECOMMENDATIONS

GENERAL RECOMMENDATIONS FOR LONG-TERM CARE FACILITIES

General infection control measures are appropriate for preventing the spread of VRE.

Procedure Recommendations:

1. Inform all employees about resistant organisms and how to deal with them.
2. Observe standard precautions at all times. It is not practical nor possible to know all persons colonized or infected with VRE or other resistant organisms.

These precautions must include:

1. Washing hands before and after contact with residents. An antimicrobial hand soap may be useful when dealing with VRE contamination.
2. Wear gloves when contact with blood or body fluid is likely.
3. Wear a mask when in close contact with a resident who is coughing.
4. Wear a water-repellent gown to protect clothes when soiling with blood or body fluids is a possibility.
5. Clean the resident's environment (horizontal surfaces, etc.) daily and when visibly soiled.
6. Disinfect resident equipment (blood pressure cuffs, stethoscopes, etc.) between residents. Do not share resident personal items if VRE is not contained.
7. Colonization with resistant organisms such as MRSA or VRE is neither an indication for hospitalization nor a reason to restrict admission to a long-term care facility.
8. Isolation of residents colonized with resistant organisms such as MRSA or VRE is not indicated under most circumstances.
9. Infections with resistant organisms such as MRSA or VRE should be evaluated and treated on a case by case basis.

Reviewed 08/19

REPORTING EMPLOYEE INFECTIONS

Purpose:

To promote an environment conducive to controlling the spread of communicable diseases and to insure identification and follow-up of infections among employees.

Procedure:

1. Any employee having an active infection is responsible for reporting it to the R.N Charge Nurse for referral to the infection control nurse.
2. The infection control nurse (or DNS) is responsible for completing and maintaining the employee infection record whenever an infection is reported.
3. The infection control nurse will follow the facility's policy on work restrictions for communicable diseases.
4. The infection control nurse will consult with the Public Health Department as needed to determine current standards of practice with communicable diseases.
5. Each reported infection will be assessed and managed on a case by case basis. A physician exam/treatment may be required as appropriate.

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**SUMMARY OF IMPORTANT RECOMMENDATIONS AND WORK
RESTRICTIONS FOR PERSONNEL WITH INFECTIOUS DISEASES**

DISEASE/PROBLEM	WORK RESTRICTIONS	DURATION
Conjunctivitis	Restrict from patient contact and contact with the resident's environment.	Until discharge ceases.
Cytomegalovirus (CMV) infection	No restrictions.	
Diarrheal diseases Acute stage (diarrhea with other symptoms) Convalescent stage, Salmonella spp.	Restrict from patient contact, contact with the resident's environment, or food handling. Restrict from care of high-risk residents.	Until symptoms resolve. Until symptoms resolve; consult with local and state health 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 immune-compromised residents and their environments.	Until symptoms resolve.
H1 N1	Exclude from duty.	For 7 days or until symptoms have resolved, whichever is longer.
Hepatitis A	Restrict from patient contact, contact with the resident's environment, or food handling.	Until 7 days after onset of jaundice.

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<p style="text-align: center;">Hepatitis B</p> <p>Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures</p> <p>Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures</p>	<p>No restrictions unless epidemiologically linked to transmission of infection; refer to state regulations; standard precautions should always be observed.</p> <p>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations.</p>	<p>Until hepatitis B e antigen is negative.</p>
<p style="text-align: center;">Hepatitis C</p>	<p>No recommendation.</p>	
<p style="text-align: center;">Herpes simplex</p> <p>Genital</p> <p>Hands (herpetic whitlow)</p> <p>Orofacial</p>	<p>No restrictions.</p> <p>Restrict from patient contact and contact with the resident's environment.</p> <p>Evaluate for need to restrict from care of high-risk residents.</p>	<p>Until lesions heal.</p>
<p style="text-align: center;">Human Immunodeficiency Virus</p>	<p>Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations.</p>	
<p style="text-align: center;">Measles</p> <p>Active</p> <p>Post exposure (susceptible personnel)</p>	<p>Exclude from duty.</p> <p>Exclude from duty.</p>	<p>Until 7 days after the rash appears.</p> <p>For the 5th day after 1st exposure through 21st day after last</p>

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		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		
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.

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<p style="text-align: center;">Staphylococcus aureus infection</p> <p>Active, draining skin lesions</p> <p>Carrier state</p>	<p>Restrict from contact with residents and resident’s environment or food handling.</p> <p>No restriction, unless personnel are epidemiologically linked to transmission of the organism</p>	<p>Until lesions have resolved.</p>
<p style="text-align: center;">Streptococcal infection, group A</p>	<p>Restrict from patient care, contact with resident's environment, or food handling.</p>	<p>Until 24 hours after adequate treatment started.</p>
<p style="text-align: center;">Tuberculosis</p> <p>Active disease</p> <p>PPD converter</p>	<p>Exclude from duty.</p> <p>No restriction.</p>	<p>Until proven noninfectious.</p>
<p style="text-align: center;">Varicella</p> <p>Active</p> <p>Post exposure (susceptible personnel)</p>	<p>Exclude from duty.</p> <p>Exclude from duty.</p>	<p>Until all lesions dry and crust.</p> <p>From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure</p>
<p style="text-align: center;">Viral respiratory infections, acute febrile</p>	<p>Exclude from duty.</p>	<p>Until acute symptoms resolve and no fever for 24 hours.</p>
<p style="text-align: center;">Zoster</p> <p>Localized, in healthy person</p> <p>Generalized or localized in immunosuppressed person</p> <p>Post exposure (susceptible personnel)</p>	<p>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).</p> <p>Restrict from patient contact.</p> <p>Restrict from patient contact.</p>	<p>Until all lesions dry and crust.</p> <p>Until all lesions dry and crust.</p> <p>From 8th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure, or, if varicella occurs, until all lesions dry and crust.</p>

EQUIPMENT/SUPPLIES CLEANING/DISPOSAL SCHEDULE

All personal resident equipment will be clearly dated and marked with the resident's name.

1. BSU (Foley) bags will be changed weekly and documented on the treatment sheet.
2. Foley catheters will be changed on a monthly basis (unless otherwise specified by primary MD) and PRN if leakage or blockage occurs and documented on the treatment sheet.
3. Denture cups will be discarded and re-issued monthly.
4. Nebulizer machine, tubing & attachments will be changed on the 5th of each month. Nebulizer attachments will be soaked and rinsed with water, then set on a paper towel to dry after each use.
5. Oxygen tubing will be changed on the 5th of each month and PRN as needed.
6. In room suction machines will utilize disposable canisters and discarded in a bio hazard container when full and between each individual resident use. Tubing/suction catheter will be changed after each use. If ongoing use for an individual resident is required tubing/suction catheter change will be marked, dated and changed Q24 hours.
7. Tube feeding pole and pump will be wiped down weekly (NOC shift) and PRN when visibly soiled.
8. Tube feeding syringe will be changed on a daily basis.
9. Urinals will be replaced on the 5th of each month and PRN.
10. Urine/stool specimen hats shall be marked with the resident's name and will be discarded following individual use.
11. Water Pitchers will be changed daily.
12. Portable Suction Machine (Crash Cart) will be cleaned weekly and pm soiled
13. Bladder Scanner will be cleaned weekly and after each use, following the manufacturer's recommendations for cleaning.
14. Glucometers are cleaned/disinfected after each use.

Reviewed 12/19

STERILE SUPPLY STORAGE

Purpose:

To maintain the sterile integrity of sterile supplies in a clean environment.

Procedure:

1. Sterile supplies will be stored in an environment with limited staff access and clean conditions.
2. Sterile supplies will be kept intact and not opened until ready for use to maintain the sterility of the product.
3. Sterile supplies will be checked periodically for expiration dates and discarded as deemed necessary.
4. Sterile supplies whose outer packages have become damaged or soiled during storage in such a way that the integrity of the product is in question, will not be used but will be discarded appropriately.

Reviewed 08/19

INFLUENZA VACCINATIONS

Purpose:

To provide the residents of ISVH-L with the opportunity to be protected against the Influenza Virus in accordance with state and federal guidelines and with interventions that are consistent with current professional standards of practice.

Protocol:

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

ISVH-L will adhere to the following Influenza Vaccinations Protocols unless directed otherwise by the residents' primary physician.

1. Residents are protected from the Influenza Virus by being offering the vaccine annually.
 - a. All residents will be offered the vaccination with the exception of those residents with known allergies to eggs and/or a prior history of severe reaction to the vaccination.
 - b. If a resident declines the influenza vaccine, he or she will be educated to the risks and benefits of receiving the vaccine and will be asked to sign an informed consent form which will be placed in the resident's chart.
 - c. The infection control nurse arranges with the nursing department as to when the vaccinations will be administered and will coordinate with the pharmacy as to availability of vaccinations.

Attached is the procedure for nurses to follow when giving the vaccinations.

Reviewed 08/19

ANNUAL FLU VACCINATION CRITERIA

The following considerations need to be assessed prior to administration of the flu vaccination:

_____ A physician order is on file stating the resident may receive the flu vaccine.

_____ The resident has not previously received the flu vaccine at another facility.

_____ The resident is afebrile.

_____ The resident is not currently taking antibiotics. If the resident is currently taking an antibiotic; the physician is to be consulted prior to administration of this vaccine.

_____ The resident has no known allergies to eggs. Consult with the Physician if an allergy is identified.

_____ A second vaccination may be offered in January dependent on supplies and voracity of current influenza.

The following nursing interventions will be followed:

_____ An entry will be made in the resident's chart reflecting the above information, site and date given, and the residents tolerance of the

Procedure:

The resident will be placed on alert charting for the following 72 hours. During this time, the nurse will inspect the vaccination site and obtain the resident's temperature daily to ensure that an adverse reaction has not occurred. A notation will be placed in the chart regarding this assessment.

Revised 08/19

SAMPLE STANDING ORDERS/PROTOCOL

Seasonal Influenza Symptoms

1. Temperature equal to or greater than 99.0 degrees.
2. Dry Hacking Cough.
3. Muscular aches & pains.
4. Chills.
5. Tiredness (malaise)
6. Runny nose.
7. Sneezing.
8. Nasal stuffiness.
9. Headache
10. Sore Throat
11. Chest Discomfort (congestion)
12. Loss of appetite. ‘
13. Dizziness and/or nausea vomiting. Diarrhea is common.

Protocol:

1. All residents will be offered the influenza vaccine annually.
2. A second influenza vaccine will be offered in January to all residents if recommended by physician. (This repeat vaccine is dependent on the availability (quantity) of the vaccine for that year.

Treatment for Flu Symptoms:

1. Residents with active signs and symptoms of Influenza will be given Tamiflu 7 5mg. PO
2. BID X 5days. (Need to start within 48 hours of onset of symptoms.)
3. *(For adults with a creatinine clearance of 10-30-minute, reduce dose to 75mg. PO QD.)*
4. To prevent Influenza after close contact with an infected resident, all residents without signs & symptoms will be offered Tamiflu prophylactically. For prophylactic treatment, the dosage is 75mg. PO QD X 10 Days.

(For adults with a creatinine clearance of 10-30ml/minute. reduce dose to 75 m Po QOD)

Physician Signature

Date

Reviewed 08/19

PNEUMOCOCCAL VACCINATIONS

Purpose:

To provide the residents of ISVH-L with the opportunity to receive the Pneumococcal Vaccine in accordance with state and federal guidelines and in accordance with current professional standards of practice.

Protocol:

- ISVH-L subscribes to providing the highest quality of care to all of its residents.
- ISVH-L will adhere to the following Pneumococcal Vaccinations Protocol unless directed otherwise by the residents' primary physician.

Upon admission to the facility, the residents' medical history will be reviewed to determine evidence of (or lack of) prior pneumococcal vaccination.

1. Should the resident's medical history show that the resident has received both of the two vaccinations needed to fulfill the lifetime requirement; this will be documented, and no further pneumococcal vaccines will be necessary.
2. Should the resident's medical history indicate that the resident has either received the pneumococcal vaccine, or has not received the second injection needed to complete the lifetime requirement the following criteria will be followed:
 - a) An order will be obtained for the vaccine and informed consent obtained.
 - b) The resident's temperature will be taken prior to administering the vaccine. Vaccination will be delayed for those residents with a fever 100 F. or the presence of an active upper respiratory infection (URI).
 - c) If a resident declines the pneumococcal vaccine, he or she will be educated to the risks and benefits of receiving the vaccine and will be asked to sign an informed consent form which will be placed in the resident's chart.
 - d) The vaccine is administered intramuscularly into the deltoid muscle.
 - e) The resident will be monitored for any initial adverse reactions to the vaccine. For the next 72 hours following vaccination; nursing will continue to assess and record any adverse reactions such as low-grade fever, malaise, and soreness at the injection site and treat these symptoms as appropriate.
 - f) A nursing entry will be made in the nursing progress notes identifying the date, time and site of injection. The vaccine will be recorded in the EMAR and the Vaccination Record in the electronic medical record.

Reviewed 08/19

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PNEUMOCOCCAL IMMUNIZATION INFORMED CONSENT

Pneumococcal disease is a serious disease that causes much sickness and death. Anyone can get pneumococcal disease.			
RESIDENTS AT RISK FOR SERIOUS COMPLICATIONS		COMPLICATIONS	
<ul style="list-style-type: none"> • Residents 65 years of age and older • Residents with special health problems such as: <ul style="list-style-type: none"> • Alcoholism • Heart disease • Lung disease • Kidney failure • Diabetes • HIV infection • Certain types of cancer 		Pneumococcal disease can lead to: <ul style="list-style-type: none"> • Serious infections of the lungs (pneumonia) • Infection of the blood (bacteremia) • Infection of the covering of the brain (meningitis) 	
VACCINATION			
Usually one dose of PPV is all that is needed. However, under some circumstances, a second dose may be given. <ul style="list-style-type: none"> • A second dose is recommended for those people aged 65 and older who got their first dose when they were under 65, if 5 or more years have passed since that dose. • A second dose is also recommended for people who: <ul style="list-style-type: none"> • Have a damaged spleen or no spleen • Have sickle-cell disease • Have HIV infection or AIDS • Have cancer, leukemia, lymphoma, multiple myeloma • Have kidney failure • Have nephrotic syndrome • Have had an organ or bone marrow transplant • Are taking medication that lowers immunity (such as chemotherapy or long-term steroids) 			
SIDE EFFECTS OF PNEUMOCOCCAL VACCINE			
Side effects of PPV are usually very mild. The experienced side effects may include: <ul style="list-style-type: none"> • Slight discomfort or pain • Redness where the shot is given • Soreness of the arm • Slight fever (occasionally) • Muscle aches (occasionally) • Joint aches (rarely) • Rash (rarely) 			
<input type="checkbox"/> I hereby give the facility permission to administer a pneumococcal vaccination. I have been educated on the benefits and risks associated with the pneumococcal vaccine.			
_____ Resident/Legal Representative		_____ Date Signed	
_____ Signature/Title - Witness		_____ Date Signed	
<input type="checkbox"/> I hereby decline my permission for the facility to administer a pneumococcal vaccination. I have been educated on the benefits of receiving the pneumococcal vaccination and the risks associated with not receiving the pneumococcal vaccination.			
_____ Resident/Legal Representative		_____ Date Signed	
_____ Signature/Title - Witness		_____ Date Signed	
NAME-Last	First	Middle	MR #

**PNEUMOCOCCAL IMMUNIZATION
INFORMED CONSENT**

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-Lewiston, 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.

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- 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.

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

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- 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 Healthy and Human Services. *State Operations Manual (SOM): Appendix Z Guidance to Surveyors for Long Term Care Facilities*. (March 2019 Revision) *Emergency Preparedness* 483.73.
- b. 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>)

Signature_____

Date_____

Reviewed: 02/2020

XI PHYSICAL / CHEMICAL RESTRAINTS

CHEMICAL RESTRAINTS – USE OF PSYCHOTROPIC MEDICATIONS

Purpose:

Our residents have the right to be free from any chemical restraint imposed for purposes of discipline or convenience and should only be used to treat the resident's medical symptoms. Because of this, the use of psychotropic medications will only be ordered/administered using the following procedure.

Procedure:

1. Prior to obtaining an order for the addition or increase in a psychotropic medication the nurse, along with the resident's physician, must:
 - a) Assess whether the resident's behavioral symptom(s) is in need of some other form of intervention than the use of an antipsychotic medication.
 - b) Assess whether the resident's behavioral symptom(s) is in need of an antipsychotic medication.
 - c) Determine whether the behavioral symptom(s) is transitory or permanent.
 - d) Attempt to determine the cause of the behavior.
 - e) Rule out environmental causes such as excessive heat, noise, overcrowding.
 - f) Rule out medical causes such as pain, constipation, fever, infection.
2. The results of the above shall be documented in the resident's medical chart, by the licensed nurse and physician.
3. Prior to the administration of a new antipsychotic medication and/or prior to the administration of an increase in the dose of a psychotic medication the licensed nurse must:
 - a) Notify Social Services
 - b) Notify the resident and/or responsible party to discuss/explain the potential negative outcomes of chemical restraint use and obtain consent for use.
 - c) Notify the RN Manager or DNS (if not originally involved in the decision).
 - d) Implement a care plan.
 - e) Implement monitoring tool for observation of potential side effects of medication(s) (on MAR).
4. Prior to the use of a PRN psychotropic medication, the licensed staff must first utilize other care planned alternative interventions to alleviate the resident's behavior and document the behavior, the results of the intervention(s) and the outcome of the intervention(s) in the behavior monitoring sheet/nurses' notes.
5. Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated.

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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.

Reviewed 08/19

PHYSICAL RESTRAINT USE/EVALUATION

Purpose:

The purpose of this procedure enables this facility to utilize physical restraints only when alternative interventions to protect the resident's safety have been exhausted, or when the resident has been determined to have the presence of a specific medical symptom that requires the use of a restraint to protect the resident's safety and assists the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. The use of physical restraints will be evaluated on a continual basis and by the Physical Restraint/Reduction committee quarterly in conjunction with the resident's MPS schedule.

Pre-restraining

1. Prior to the implementation of a restraint (which includes but is not limited to lap belts) Geri chairs, bilateral side rails, bed against wall, hand mitts, lap cushions, wheelchair cushions that prevent rising, the following interventions should be considered, attempted, and documented as appropriate.
 - a) Consult with the RN Manager, and other nursing and facility staff, as appropriate.
 - b) Determine if the problem may be caused by:
 - i. Resident's hunger.
 - ii. Resident being too hot/cold.
 - iii. Resident's need to go to the bathroom.
 - iv. Resident looking for someone/something.
 - v. Resident's pain or other medical symptom, i.e., delirium r/t illness such as UTI.
 - c) Need for closer supervision such as:
 - i. Move resident's room closer to the nurses' station.
 - ii. Sit resident at nurses' station or with staff members and engage resident in activities of interest to the resident.
 - iii. Involve resident in planned activity/social services/pastoral groups as appropriate.
 - iv. Increase frequency of rounds and visual checks.
 - d) Positioning device needed such as:
 - i. Sitting on a couch or in a comfortable chair
 - ii. Gel cushion in a wheelchair
 - iii. Non-skid mat on wheelchair seat
 - iv. Use of lateral supports in wheelchair
 - v. Use of pillows in bed or elevating head/feet.
 - vi. Use of non-skid mat on floor or non-skid socks
 - vii. Referral to OT/PT for seating/positioning
 - e) Need for exercise such as:
 - i. Take resident for walk inside/outside of facility.
 - ii. Ambulate as appropriate.
 - iii. PT/OT evaluation for strengthening or ambulation program

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- f) Safety devices such as:
 - i. Visual reminders (flowers at the door, night light, slop signs, yellow tape, etc.)
 - ii. Cushion on floor by bedside
 - iii. Motion alarms (tag alarms, bed and/or chair alarms)
 - iv. Use of watch guard or other safety system
 - g) Adjust care routines such as:
 - i. Change roommates.
 - ii. Change environmental temperature.
 - iii. Change mealtimes or offer routine snacks.
 - iv. Change bath times/dates.
 - v. Change caregivers.
 - vi. Nursing to evaluate the need for a Bowel/Bladder retraining program, or scheduled toileting program, refer to Restorative as appropriate.
2. The results of these interventions should also be documented on the resident's Pre-restraining Interventions form.

Restraint Utilization

3. If the above interventions are unsuccessful, restraints may be considered, using the least restrictive, most appropriate restraints. "Physical restraint" is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Utilize the following steps when considering the TRIAL of or when establishing the use of a physical restraint. (NOTE: During normal business hours, a physical restraint will be implemented only after review by the Physical Restraint/Reduction Review Committee. During off-hours such as evenings, weekends, holidays, a physical restraint will only be implemented after contacting and reviewing need for restraint with the DNS or the RN Manager.)
- a) Complete the Pre-restraining Assessment.
 - b) RN Manager to meet with Physical Restraint/Reduction Review Committee.
 - c) Social Services or Nursing to obtain signed Consent Form for the specified restraint from resident or legal representative for health care issues.
 - d) Verbal consent for restraint to be obtained from the resident or his or her legal representative PRIOR to the implementation of the physical restraint, by the licensed staff member who obtained the physician's order for the restraint. Verbal consent must be documented in the clinical record.
 - e) Obtain physician statement related to the medical necessity for use of a physical restraint(s).
 - f) Obtain physician order to include:
 - i. Type of restraint - be specific.
 - ii. Reason for restraint use.
 - iii. Times restraint is to be applied/released (physical) (e.g. lap belt on resident while in wheelchair, check q 30 min. release q 2 hours to offer fluids, toilet,

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ROM or bilateral full side rails up when resident is in bed, check q 30 minutes, release q 2 hours to offer fluids, toilet, ambulate.

- g) Establish care plan for use of the restraint. (May utilize the Temporary Care Plan for Restraint Use form.)

Restraint Elimination

4. All residents using a “physical restraint” will be regularly assessed for possible restraint reduction, as appropriate.
5. Each quarter in conjunction with the MDS schedule and PRN as necessary, the Unit RN Manager or designee shall complete the Physical Restraint Elimination Assessment and resident will be evaluated by the Physical Restraint/Reduction Review Committee for a physical restraint reduction program implementation.
6. The nursing staff on each unit in conjunction with the committee recommendations, shall implement the restraint elimination interventions.
7. 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 assessments as mentioned above.
 - b) Physical restraint reduction or physical restraint changes will be implemented in the resident’s Interdisciplinary care plan (may utilize the Temporary Care Plan form as appropriate).
 - c) Nursing staff caring for the resident involved in a restraint reduction program or change of a physical restraint will be notified through shift report
 - d) Resident involved in a restraint reduction program or change of a physical restraint will be placed on alert charting.
 - e) Social Services or Nursing 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.
 - f) 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.
8. In the event of a failed restraint reduction:
 - a) The 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,).

Revised 08/19

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, Licensed Nurse 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 in conjunction with the resident's MDS schedule.
 - ii. All new recommendations for the use of physical restraints will be reviewed.
 - b) Medical record of designated residents who are to be reviewed by the committee will be brought to the meeting by the licensed nurse from that resident's nursing unit.
 - c) Maintain a record of all physical restraints by resident/type/unit.
 - d) Be assigned to follow through with all changes as determined by the Physical Restraint/Reduction Review Committee.

Reviewed 08/19

XI RESTORATIVE

PREVENTING COMPLICATIONS AND DEFORMITIES

Deformities and complications of illness or injury can often be prevented by frequent changes of position, proper positioning in bed and exercise.

Positioning

Purposes for Changing Positions

1. To prevent contractures.
2. To stimulate circulation and to help prevent thrombophlebitis, pressure sores and edema of the extremities.
3. To promote lung expansion and drainage of respiratory secretions.
4. To relieve pressure on a body area.

Principles of Body Alignment in Body Positioning

1. Dorsal or Supine Position
 - a) The head is in line with the spine, both laterally and anteroposteriorly.
 - b) The trunk is positioned so that flexion of the hips is minimized.
 - c) The arms are flexed at the elbows with the hands resting against the lateral abdomen.
 - d) The legs are extended with a small, firm support under the popliteal area.
 - e) The heels are suspended in a space between the mattress and the footboard.
 - f) The toes are pointed straight up.
 - g) Trochanter rolls are placed under the greater trochanters in the hip joint areas.
2. Side-Lying or Lateral Position
 - a) The head is in line with the spine.
 - b) The body is in alignment and is not twisted.
 - c) The uppermost hip joint is slightly forward and supported by a pillow in a position of slight abduction.
 - d) A pillow supports the arm, which is flexed at both the elbow and the shoulder joints.
3. Prone Position
 - a) The head is turned laterally and is in alignment with the rest of the body.
 - b) The arms are abducted and externally rotated at the shoulder joint; the elbows are flexed.
 - c) A small, flat support is placed under the pelvis, extending from the level of the umbilicus to the upper third of the thigh.
 - d) The lower extremities remain in a neutral position.
 - e) The toes are suspended over the edge of the mattress.

Reviewed 08/19

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 patient in a supine position with his arms to the side and the knees extended.
2. Hold the extremity at the joint, e.g., elbow, wrist or knee; and move the joint smoothly, slowly and gently through its range. If the joint is painful (as in arthritis) support the extremity in the muscular area.
3. Move each joint through its range of motion about three times - smoothly, rhythmically and slowly.
4. Avoid moving a joint beyond its free range of motion; avoid forcing movement. The motion should be stopped at the point of pain.
5. When painful muscle spasm is present, move the joint slowly to the point of resistance. Then exert gentle, steady pressure until the muscle relaxes.

Definitions

Abduction	Movement away from the midline of the body.
Adduction	Movement toward the midline of the body.
Flexion	Bending of a joint as the angle of the joint diminishes.
Extension	The return movement from flexion; the joint angle is increased.
Inversion	Movement that turns the sole of the foot inward.
Eversion	Turns the sole of the foot outward.
Dorsiflexion	Flexing or bending the foot toward the leg.
Plantar Flexion	Flexing or bending the foot in the direction of the sole.

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Pronation	Rotating the forearm so that the palm of the hand is down.
Supination	Rotating the forearm so that the palm of the hand is up.
Rotation	Turning or movement of a part around its axis. <ul style="list-style-type: none">▪ External: Turning outward, away from the center.▪ Internal: Turning inward, toward the center.

Reviewed 08/2019

ASSISTING THE PATIENT WITH AMBULATION

Transfer Activities

A transfer is the movement of the resident from one piece of furniture or equipment to another (from bed to chair, bed to commode, bed to wheelchair).

Weight-bearing transfers are carried out by residents who have at least one stable lower extremity (hemiplegics, unilateral lower extremity amputees, residents with hip fractures).

Non weight-bearing transfers are done on residents who are unable to assist with transfers at all.

Preparation of Transfers

Objective: To develop ability to raise and move the body in different positions.

1. Technique for Moving 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 patient 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.
2. Technique for Sitting the Resident on the Edge of the Bed
 - a) Place one hand under resident's shoulders.
 - b) 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).
3. 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.

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4. Technique for Transfer by Sliding Board

- a) A sliding board (or transfer board) is a polished, lightweight board that is used to bridge the gap between the bed and the chair (or chair and tub, etc.)
- b) When the muscles that the resident uses to lift himself off the bed are not strong enough to overcome the resistance of body weight, use the following maneuver:
 - i. Place one side of the sliding board under the resident's buttocks and the other side on the surface of the chair, bed toilet, etc., to which the transfer is being made.
 - ii. Instruct the resident to push up with his hands, to shift his buttocks and to slide across the board to the other surface.

Reviewed 08/19

TECHNIQUE FOR WALKING WITH A CANE

Instruct patient as follows:

1. Hold the cane in the hand opposite the affected extremity; i.e., the cane should be used on the good side.
2. Move the cane at the same time the affected leg is moved.
3. Keep the cane fairly close to the body to prevent leaning.
4. When climbing steps:
 - a) Step up on unaffected extremity.
 - b) Then place cane and affected extremity on the step.
 - c) Reverse this procedure for descending steps.
 - d) The strong leg goes up first and comes down last.

Reviewed 08/19

HYDRAULIC RESIDENT LIFT

The hydraulic lift may be utilized for resident transfer.

In as much as no two residents are alike, a reasonable amount of caution shall be exercised to establish the most effective management of resident transfers. Resident transfers shall be performed with a minimum of two (2) nursing staff

Bed To Chair

Procedure:

1. Assemble and check equipment and explain procedure to resident.
2. Allow room for maneuvering.
3. Position seat sling underneath resident.
4. Refer to appropriate manufacturer's instructions for proper use of equipment.
5. Once resident is securely transferred, all attachments may be released.

Reviewed 08/19

HYDROCOLLATOR PACKS

The purpose of the Hydrocollator Packs is to decrease pain in a specific joint.

The Hydrocollator packs can be dispensed by the Physical Therapy Department.

Procedure:

1. Temperature of the hot pack machine should not exceed 165 degrees Fahrenheit. Water temperature should be tested once a quarter and changed 1 x a month.
2. Pads should be used to cover the hot packs. If the hot packs are too warm for patient comfort, more padding should be used.
3. Hot packs should be placed only on the area designated by the Physical Therapist in the 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 patient should be supervised at all times while the hot packs are being used.
6. Upon removal of the hot packs, the area should be examined for any redness.

Reviewed 08/19

XII SKILLED NURSING

BLOOD GLUCOSE MONITORING SYSTEM - QUALITY ASSURANCE

Purpose:

To validate the performance of the 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:

- 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:

- Glucometer
- Blood glucose Test Strips (Do not use Test Strips 120 days past written opened date or after EXP date printed on Test Strip vial label.)
- Control test solution bottle (Do not use control if 120 days past written opened date or after EXP date printed on control)
- Discard out of date products and use new products if either dates have passed and notify supply.

Performing a Quality Control Test:

1. Remove a test strip from the vial and recap the vial immediately. If opening a new box of test strips, write the expiration date on the vial. If box has already been opened, check that the expiration date on the vial valid. Test strips are to be used within 120 days of opening.
2. With meter off, insert test strip contact end into the test port.
3. Wait until the Drop symbol appears in the display.
4. While Test Strip is in the meter touch edge of Test Strip to drop of control and allow drop to be drawn into Test Strip.

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5. When a “beep” is heard, leave the meter on a flat surface while waiting for the test result. The screen will show a countdown mode.
6. Tightly recap the control solution.
7. 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.
8. If the control solution test results are out of the control solution range, the 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.
9. Repeat the Quality Control Test using a new Test Strip. If the control solution tests outside the range again, do not use the system to test blood glucose. Call Central supply and ask for a replacement.
10. If the result is in range, the glucometer can be used for testing blood. Record the result in the Quality Control log.

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QUALITY CONTROL RECORD

Meter Serial Number _____ (7-digit number on Meter label below the bar code) **Note any problems in Troubleshooting

Date	Time	TEST STRIPS			GLUCOSE CONTROL - LEVEL _____					GLUCOSE CONTROL - LEVEL _____		
		LOT	EXP	Date Opened	LOT	EXP	Date Opened	Acceptable Range	Result	LOT	EXP	Date Opened
		On control test Strip vial label, write date vial opened. Discard vial if either 120 days after opening or after EXP date printed on the vial label has passed.			On control bottle label, write date bottle opened. Discard bottle if either 3 months after opening or after EXP date printed on the bottle label has passed.			Printed on vial label of Test Strips being used.		On control bottle label, write date bottle opened. Discard bottle if either 3 months after opening or after EXP date printed on the bottle label has passed.		

TROUBLESHOOTING

Date	Problem	Action

Meter Serial Number _____ (7-digit number on Meter label below the bar code) **Note any problems in Troubleshooting below.**

Date	Time	TEST STRIPS			GLUCOSE CONTROL - LEVEL _____					GLUCOSE CONTROL - LEVEL _____		
		LOT	EXP	Date Opened	LOT	EXP	Date Opened	Acceptable Range	Result	LOT	EXP	Date Opened

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. Assess the resident prior to and upon return from the dialysis unit.
 - a. Take vital signs, BIP, temperature, pulse, and the respirations.
 - b. Obtain residents weight.
 - c. Check for bruit and thrill at the vascular access site.
 - d. Check for bleeding.
 - e. Check for S/S of infection at vascular site (i.e. erythema, excessive tenderness, swelling, drainage).
 - f. Check condition of resident.
 - g. Document on the dialysis report (see attached).
 - h. Do not allow the resident to wear constricting clothes over the area.
 - i. Do not allow anyone to take a blood pressure or blood sample on the graft arm or leg.
 - j. Do not allow the resident to carry anything heavier than 10 pounds with the arm that has a graft.
2. Licensed nurse assigned to resident shall review returned dialysis report and follow up with any physician orders or special problems encountered during dialysis.

Revised 08/19

DRESSING CHANGES

Protocol for dressing changes will be as follows:

1. Sterile technique will be followed post-operatively for all surgical interventions or debridement 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.
 - a) A physician order will reflect need for sterile dressing.
 - b) Sterile dressing changes will include steps outlined under #2, as applicable.

2. All other dressing changes will follow a modified “clean” technique.
 - a) Make sure the resident is in a comfortable position, screened to allow privacy and draped to prevent chilling.
 - b) Wash hands.
 - c) Establish a clean field, i.e. clean towel, blue pad, or packaging wrapper, to prevent contact with soiled surfaces.
 - d) Assemble supplies required for procedure.
 - e) Open and set up supplies, tear tape, open dressing packages, remove caps from ointments or solutions. Pour onto dressing if required.
 - f) Protect underlying areas if excess leakage is anticipated, with waterproof drape.
 - g) Glove.
 - h) Remove soiled dressing.
 - i) Hold soiled dressing in one hand, pull glove over dressing and off hand; repeat with remaining glove, turning inside out and discard in appropriate receptacle.
 - j) Wash hands and re-glove.
 - k) Cleanse wound, taking care to work from mid-line out. Do not re-contaminate already cleansed area
 - l) Apply ointment, cream, or solution using clean applicator (i.e. q-tip, tongue blade or irrigation syringe.)
 - m) Re-dress.
 - n) Clean work area, discarding all contaminated materials in appropriate receptacle or double bag if required.
 - o) Leave unused dressings or supplies at bedside or discard if contaminated.
 - p) Ensure that no sharp objects are left in trash or linens that could puncture bags or cause staff injury.
 - q) Wash hands.

Revised 08/19

INJECTIONS

Subcutaneous Injections:

1. Medications administered via subcutaneous injection must be ordered via that route/type of injection.
2. Medications typically ordered via subcutaneous injection are insulin and heparin.
3. Subcutaneous injections are typically administered through a 27-gauge needle - tuberculin-type syringe.
4. 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 medication administration record (MAR), including site.

Intra-Muscular Injections

1. Medications administered via intra-muscular injection must be ordered via that route/type of injection.
2. Medications typically ordered via intra-muscular injection are antibiotics and vaccines.
3. Intra-muscular injections are typically administered through a 1.5 to 3 inch 19 - 23-gauge needle.
4. Sites used are deltoid, ventrogluteal, dorsogluteal, and lateralis muscles.
5. No more than 2 cc. is typically administered into one site.
6. To administer an intra-muscular injection:
 - a) Position resident, select site, and clean site with alcohol sponge.
 - b) Insert needle quickly at 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 medication administration record (MAR), including site.
 - g) Observe resident for adverse reactions. If side-effects are present, notify the nurse manager and physician. Document in nurse progress notes and complete an adverse drug reaction form.

Revised 08/19

PERFORMING A BLOOD GLUCOSE TEST

Procedure:

1. Carry meter with supplies to resident's bedside.
2. Place case on a clean paper towel.
3. Provide for resident's privacy.
4. Wash hands and apply gloves.
5. Place blood glucose meter and supplies on another clean paper towel to provide a clean working surface.
6. Check test strips vial to ensure that it is dated. Test strips are good for 120 days from the day they are opened or after EXP date printed on Test Strip vial label.
7. Remove a new test strip from the vial and re-cap the vial immediately.
8. Insert the test strip contact end (contacts facing up) into the test port.
9. Push the test strip in until it snaps firmly into place. The meter will turn on automatically when test strip is inserted or when "s" button is pressed.
10. Check that the code number blinking on the meter matches the code highlighted on the vial of test strips currently in use.
11. Prepare residents fingertip with an alcohol pad and allow to air dry.
12. Place the end of the single use lancet against the fingertip and release the trigger to obtain a blood sample.
13. While the "**Drop**" symbol is flashing, apply the blood sample.
14. Touch the blood drop to the sample entry of the strip. The blood will be drawn into the strip automatically.
15. Hold the finger on the test strip sample tip entry until a "beep" is heard. Once beep is heard remove finger from test strip meter is testing.
16. When blood is applied to the test strip, the countdown mode will appear on the screen.
17. The blood glucose result appears after the measurement is completed. The result is displayed in mg/dl. The result with time and date is automatically stored in the meters memory.
18. Remove used test strip and discard.
19. Sanitize blood glucose machine using a 10:1 bleach solution wipe three times up and down screen and three times side to side. Allow to dry before next use.
20. Remove gloves and wash hands.
21. Discard the used lancet in the sharps container.
22. Chart blood glucose results in MAR.
- 23.

**Glucometer system reads blood glucose levels from 40 to 600 mg/dl. If test result is less than 40 mg/dl, "LO" appears in meter display. If the test result is greater than 600 mg/dl, "HI" appears in the meter display.

Reviewed 08/19

OXYGEN THERAPY - RESPIRATORY CARE

1. Oxygen is administered appropriately to residents 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.)
 - d) Humidification is recommended for liter flows greater than 4 liters.
2. Oxygen tanks are kept in the oxygen closet.
3. If supplies are not available, storekeeper may be contacted.
4. E tanks (small green) are typically used when the resident is mobile. Tanks (large green) are for use at a wheelchair and wall oxygen is used for emergency only.
5. Concentrators (for below 5 liters) should be utilized.
6. Place oxygen sign on doorjamb entering room.
7. Cannulas are the preferred equipment unless the resident is a mouth breather.
8. Obtain protective foam covers for tubing around ears as needed.
9. Change masks and cannula as needed and in accordance with the facility's equipment changeover schedule.
10. Update resident's care plan as needed.

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RESUSCITATION

1. Residents, Legal Guardians, and families are encouraged to discuss and explore code/resuscitation decisions with Nursing staff; Social Services, the Physician, Family Nurse Practitioner and/or the Chaplain and complete advanced directives prior to or immediately following admission to the facility.
2. The decision regarding FULL or DNR/DNI CODE status will be clearly delineated in the individual resident's medical record.
3. In the event of cardiac/pulmonary arrest (absence of pulse and respiration and loss of consciousness) the resident's code status will be identified and followed per directive(s).
4. In the event a resident has FULL CODE status and an arrest has been witnessed/diagnosed:
 - a) Nurse, with assistance when possible, initiates CPR immediately.
 - b) 911 is accessed.
 - c) Facility staff contact resident's physician/FNP to relay resident current condition and to obtain further instructions.
5. EXCEPTIONS to instituting CPR when the resident has FULL CODE status and an arrest has been diagnosed are as follows:
 - a) Resident's arrest was not witnessed, and time of arrest cannot be determined.
 - b) Resident's pupils are significantly dilated and non-reactive, and;
 - c) Resident's temperature is significantly below his/her normal range, and;
 - d) Following the above determination, staff will contact resident's physician/FNP to relay resident current condition and to obtain further instructions.
6. 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.
7. In the event of a resident's death the Postmortem Procedure shall be following.
8. All resident assessment and resuscitation/intervention information will be entered in the resident's medical record in the progress note section.

Reviewed 08/19

TRACHEOSTOMY SUCTIONING

Purpose:

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

Procedure:

1. Explain procedure to resident and provide privacy.
2. 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 eye cover.
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, wash hands, remove and wash protective eye cover.
21. Chart procedure, amount and nature of secretions, resident's tolerance of procedure.
22. Inform Unit Manager of any adverse reactions.
23. Never allow secretions collecting in suction bottle to exceed 500cc.
24. Discard suction boule into medical waste trash in the soiled utility room.

Reviewed 08/19

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

Resident Preparation/Procedure:

6. Explain procedure to resident and provide privacy.
7. Place resident in semi-Fowler's position
8. Put on clean gloves.
9. Remove inner cannula and place in hydrogen peroxide and let soak.
10. Suction entire length of outer cannula.
11. Discard used suction catheter.
12. Remove soiled dressing and discard.
13. Remove gloves and put on a set of sterile gloves.
14. Using wire brush, insert it into inner cannula to remove any secretions.
15. Place inner cannula in basin of normal saline to wash off hydrogen peroxide, shake off excess saline.
16. Replace inner cannula and lock in place.
17. Clean around stoma with Q-tips, alternating hydrogen peroxide and normal saline.
18. Using precut tracheostomy dressing, place around tracheostomy.
19. If tracheostomy tapes are soiled, replace them. Cut a slit approximately 1 to 1 ½ inches from end of new tapes. Place tapes through tracheostomy openings and tie before removing soiled tapes.
20. Document in medical record the amount and character of drainage, condition of stoma and skin, and other pertinent observations.
21. Inform Senior RN or designee of any adverse reactions.

Reviewed 08/19

URINARY/SUPRAPUBIC UROSTOMY CATHETER INSERTION

1. Catheters (urinary and suprapubic) are ordered by the 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 in the event 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 procedure to resident and provide privacy.
3. Wash hands 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 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) Hold penis at right angle from body. Gently insert catheter 6 to 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 surrounding area. Gently insert catheter into urethra until urine appears.
 - c) Insert catheter in opening, advance until urine passes through catheter opening and advance 2 to 3 inches, then inflate balloon with water.
9. 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.
10. If drainage is poor, ensure catheter is not kinked.
11. Empty drainage bag PRN and q shift.
12. Document in the nurse progress notes (or MAR) the reason for replacement or removal with date, time, size, type of catheter used and size of balloon.

Revised 08/19

(P.I.C.C.) CATHETER DRESSING CHANGE

PERIPHERALLY INSERTED CENTRAL CATHETER

NOTE: P.I.C.C. line dressing will be changed 24 hours after initial insertion of the catheter, unless otherwise indicated by physician, and then every seven days after the insertion. The dressing will be changed more often if it becomes loose, contaminated or the site bleeds.

PROCEDURE:

STEPS	KEY POINTS
1. Explain procedure to the patient and their role in helping to maintain the sterility of the procedure.	Encourages cooperation and prevents accidental contamination of the sterile field or equipment.
2. Don face mask and exam (non-sterile) gloves.	Reduces transmission of microorganisms; standard precautions (face mask is in first layer of sterile wrap in dressing kit.)
3. Remove old dressing and discard in appropriate receptacle.	Exposes the catheter site for inspection and cleansing.
4. Inspect catheter, insertion site and surrounding skin.	Detects signs of infection, catheter dislodgement or leakage.
5. Remove non-sterile gloves and discard. Open kit and don sterile gloves provided.	Maintain aseptic techniques
6. Utilize the solutions within the kit with swabs provided to cleanse the site. Begin with swabs soaked with hydrogen peroxide at the insertion site using concentric circles; cleanse the skin with one swab at a time.	a) Remove old blood and debris from the b) Outward circular cleansing prevents contamination of the insertion site of the catheter.
7. After dry, cleanse with chlorhexidine swabs, one at a time with back and forth motion.	a) Chlorhexidine is the antimicrobial cleansing agent of choice. b) Solution reduces the rate of re-colonization of skin micro flora.
8. Apply skin protectant to the skin where the edges of the dressing are to be placed.	a) Protects the skin from injury upon removal of tape. b) Do not apply within 1” of the insertion
9. Take one sterile 2x2 from the kit and place under the winged end of the PICC. Place the second 2 x 2 over the top of the end, tape in place over the middle and lower end of the 2 x 2.	a) Prevents hub from going into skin and creating a pressure sore. b) Utilize tape as provided in kit for securing gauze into place. c) If STAT-LOCK catheter secure device is used, gauze is not needed.
10. Place transparent dressing lengthwise over P.I.C.C. and 2 x 2's. Have the patient hold	a) Start with the center insertion site and work to edges in placing the dressing.

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their arms as straight as possible.	Provides occlusive seal to prevent site contamination. b) The skin protectant may be utilized to seal the edges of the transparent dressing as it is smoothed in place.
11. Take a piece of medipore tape provided in the kit to seal the tegaderm dressing.	a) Provides a seal at the catheter/skin area to ensure dressing patency around the catheter. b) Do not excessively tape over the tegaderm or catheter lock device. c) Prevents catheter dislodgement and/or disconnection.
12. Place date and initial dressing change onto tape.	a) Provides easy check to when the next change is due by any nurse checking the site.
13. Remove and discard gloves and supplies from kit.	a) Standard precautions.
14. Wash hands.	a) Reduces the transmission of microorganisms' site.
15. Document the procedure in the resident's MAR under "IV Site Care" and/or computer documentation.	a) Provides record of nursing care, patient response, assessment and outcome.
16. Document any unusual appearance (redness, drainage or tenderness).	a) Signs may be noting an infectious process occurring at insert site.
17. Charge for supplies used for procedure.	a) Utilize patient charge sheet.

Reviewed 08/19

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XIII INTRAVENOUS THERAPY

HEPARIN/SALINE LOCK MAINTENANCE PROCEDURE

1. The heparin lock will be maintained by an RN or an IV certified LPN.
2. Heparin/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. Heparin is not compatible with all medications and will only be used when specifically ordered as a flush by the resident's physician.
5. The following procedure shall be utilized when flushing an IV heparin lock
 - a) Flush catheter with normal saline before administering medications, typically 5cc.
 - b) Administer medications (if applicable).
 - c) Flush catheter with normal saline following administering medications, typically 5cc.
 - d) "Lock" catheter with heparin flush, utilizing 10-100 unit per cc. As ordered.
 - i. 1 cc. For peripheral IVs
 - ii. 2 cc. For midlines
 - iii. 2 ½ - 3 cc. For central lines.
 - iv. 5 cc. for implanted ports.
6. The following procedure shall be utilized when flushing a 1V saline lock.
 - a) Flush catheter with normal saline before administering medications, typically 5 cc.
 - b) Administer medications (if applicable).
 - c) Flush catheter with normal saline following administering medications, typically 5 cc., or as directed by physician.

Reviewed 08/19

IV FLUID ADMINISTRATION

Intravenous fluids used for hydration should be administered using a pump system to provide accurate infusion and to prevent 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:

All IV medications will be labeled with:

1. Name, address and phone number of dispensing pharmacy
2. Full name of resident
3. Name of prescriber/physician
4. Dispense date.
5. Prescription number
6. Name and concentration of medication
7. Name and concentration of primary solution
8. Volume dispensed
9. Directions for use including frequency, rate, and duration of administration.
10. Storage requirements
11. Expiration date.
12. Pharmacist's initials.

All IV fluids and tubing will be labeled with:

1. Any additives (e.g. potassium) to the fluids
2. Date and time put into use
3. 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.

Reviewed 08/19

IV PUSH/BOLUS

Any medication being considered for IV push use, needs to be evaluated in terms of appropriateness for administration in the long-term care setting. Some drug classifications have an increased risk of cardiac, respiratory, and other side effects.

1. A physician's order is required for IV push administration.
2. Only RNs may administer IV push medications.
3. The 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.

Reviewed 08/19

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 IV medication sheet.

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 at an alternative site as soon as possible, apply warm, moist heat to affected area.

Reviewed 08/19

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 P.I.C.C., central and subclavian lines.

Supplies:

- Two sterile injection caps
 - Two betadine swabs
 - Two alcohol wipes
 - Two syringes
 - Normal saline
1. Wash hands 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 MAR or TX sheet, as appropriate.

Reviewed 08/19

INTRAVENOUS CATHETER

1. Intravenous catheters are:
 - a. Inserted by a physician or by a registered nurse (RN)
 - b. Ordered by a physician or advanced practice registered nurse (APRN).
 - c. Maintained and discontinued by RN's.
 - d. Changed every 72 hours unless signs of phlebitis or infiltration or a physician/APRN order indicates otherwise.
 - e. Checked on each shift and as necessary and documented on the MAR
 - f. Flushed by an RN on each shift, using 3cc normal saline solution via syringe and documented on the MAR.

2. Insertion:
 - a. Verify physician/APRN order.
 - b. Assemble equipment.
 - c. Wash hands before and after procedure.
 - d. Wear gloves.
 - e. Identify resident and check identification bracelet.
 - f. Explain procedure to resident and provide privacy.
 - g. Select venipuncture site.) NOTE: antecubital space is used only as a last resort and legs are not used unless otherwise specified by the physician/APRN).
 - h. Recommended IV catheter gauge: 18 gauge for blood administration and 20 or 22 gauge for IV medications if possible.
 - i. Clean area with povidone-iodine and insert IV catheter. (Alcohol swab may be used if resident is allergic to povidone-iodine.)
 - j. Pull back on stylet about ¼ inch and thread IV catheter further into vein if necessary. Remove stylet while applying pressure beyond catheter and connect venous access device into but of catheter that has been filled with Normal Saline.
 - k. Instill 3 cc of normal saline solution and flush device.
 - l. Secure IV catheter with access device using tape or op site.
 - m. Label dressing with date and time of insertion, type and gauge of needle used, and initials or RN doing insertion.

3. Maintenance:
 - a. Access IV device, swab with alcohol, insert syringe, inject 3cc of normal saline solution so that entire catheter and access device are flushed.
 - b. Check for infiltration. If infiltration has occurred the RN will reinsert a new one as needed.
 - c. Dispose of syringe in proper receptacle.
 - d. Document on the Medication Administration Record.

4. Discontinuation
 - a. Carefully remove tape and dressing from IV catheter and access device, using gloves during procedure.
 - b. Hold a dry sterile gauze over the venipuncture site and remove the IV catheter. All RN's can discontinue Sites.

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- c. Apply firm pressure to the site to promote homeostasis.
- d. When bleeding has stopped, apply a Band Aid.
- e. Inspect the catheter to ascertain that it is not frayed or broken.
- f. Document in the clinical notes and MAR the date, time, location, type and gauge of catheter and condition of area.
- g. Update resident care plan.

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PERIPHERAL IV CATHETER REMOVAL

1. A peripheral device will be removed upon any of the following conditions:
 - a. A physician's order.
 - b. Evidence of infiltration, phlebitis, Leaking, infection, or other abnormalities.
 - c. Complaints of pain.
 - d. Duration of three days or longer.
2. The following procedure will be utilized:
 - a. Clamp IV tubing if resident has continuous infusion.
 - b. Stabilize catheter by pressing on it with one hand while gently stretching and peeling transparent dressing with the other. Remove dressing.
 - c. Inspect site for complications.
 - d. Gently remove IV device from the vein.
 - e. Apply a folded, sterile 2x2 to the site, exerting gentle pressure for at least one minute. Elevate extremity slightly when able. Secure gauze firmly with tape.
3. Document removal including:
 - a. Date and time.
 - b. Site assessment and location.
 - c. Condition of catheter upon removal.
 - d. Reason for removal of catheter.

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XIV BEHAVIORAL HEALTH SERVICES

BEHAVIORAL HEALTH

PROCEDURE:

It is the procedure of this facility that all residents receive necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.

DEFINITIONS:

“Mental disorder” is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

“Substance use disorder” is defined as recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment, such as health problems or disability.

“Non-pharmacological intervention” refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident’s mental, physical, and psychosocial well-being.

“Mental and psychosocial adjustment difficulty” refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident’s typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms.

PROCEDURE EXPLANATION AND COMPLIANCE GUIDELINE:

1. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident’s mental and psychosocial status and providing person-centered care. This process includes:
 - a. PASARR screening;
 - b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health;
 - c. MDS and care area assessments;
 - d. Ongoing monitoring of mood and behavior;
 - e. Care plan development and implementation, and
 - f. Evaluation.

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3. The resident and family are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as appropriate. The care plan shall:
 - a. Be person-centered,
 - b. Provide for meaningful activities which promote engagement and positive, meaningful relationships;
 - c. Reflect the resident's goals for care,
 - d. Account for the resident's experiences and preferences, and
 - e. Maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.
4. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment. Topics of training may include, but are not limited to:
 - a. Implementing non-pharmacological interventions;
 - b. Communication and interpersonal skills that promote mental and psychosocial well-being;
 - c. Promoting residents' independence;
 - d. Respecting residents' rights;
 - e. Caring for the residents' environment and providing an atmosphere that is conducive to mental and psychosocial well-being;
 - f. Mental health and social service needs, and
 - g. Care of cognitively impaired residents.
5. Interventions shall be evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.
6. Behavioral health care and services shall be provided in an environment that promotes emotional and psychosocial well-being, supports each resident's needs and includes individualized approaches to care.
7. Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated.
8. The facility may utilize individualized, non-pharmacological interventions to help meet behavioral health needs. Examples may include, but not limited to:
 - a. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);
 - b. Exercise;
 - c. Pain relief;
 - d. Individualizing sleep and dining routines;
 - e. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;
 - f. Adjusting the environment to be more individually preferred or homelike;
 - g. Consistent staffing to optimize familiarity;
 - h. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs;
 - i. Utilize techniques such as music, art, massage, aromatherapy, reminiscing;

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- j. Assisting residents with substance use disorders to access counseling programs to the fullest degree possible.
9. Behavioral health care plans shall be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.
10. The Social Services Department shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists.

Reviewed: 08/19

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F740** – Behavioral Health Services. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F741** – Behavioral Health Services. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F742** – Behavioral Health Services. 42 C.F.R. §483.40.