List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on April 11, 2023

Revised Hospital-wide Policies and Procedures

Dept.	Policy #	Title	Notes
_LHHPP	25-10	Use of Psychotropic Medications	1. Removed "13. Consent for psychotropic medication need not be obtained when psychotropic medications are used to treat medical conditions, such as seizures, spastic disorders, hiccups, terminal delirium, and pain" 2. Replaced Nursing Protocol for using Psychotropic Medication for Emergency to Standard Work on Emergent Medication 3. Updated references
_LHHPP	31-01	Wireless Temperature Monitoring System	1. Included medication room refrigerators 2. Updated Appendix A: Temp Trak Pager List

Revision Facility Policies and Procedures

Dept.	Policy #	Title	Notes
Facility	LS-2	Portable Fire Extinguisher Inspection and Maintenance	1. Updated inspection to monthly but no more than 31 days.

Revision Nursing Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	D1 2.0	Resident's Activities of Daily Living	When the facility decided to make razors & electric shaver as a contraband, this policy was not updated and electric shavers are still included in the items that are in the bedside
Nursing	E 2.0	Assisting Residents During Mealtime	Added "at an eye level" to Procedure B to state "Staff who are providing feeding assistance will position themselves directly across from the resident in a seated position at an eye level."

Nursing	E 5.0	Enteral Tube Feeding Management	1. Changed checking enteral tube placement via measurement of external tube placement (inspecting mouth for NG), to the following: a. every shift and as needed, prior to accessing b. FYI: still continuing upon admission and relocation, and after placement or replacement 2. Added to Policy #5 "A foley or gastrostomy tube may be placed in the stoma to keep tract open until tube can be replaced" in the event that a simple balloon GT older than 6 weeks is dislodged or clogged 3. New Policy #7 "J-tubes are replaced by IR, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR 4. Trained LVN may replace NGT as ordered (removed from Procedures and added this into Policy section) 5. Clarified use of tap water for medication dilution and accessing device flushes 6. Removed procedure instructions for NGT insertion and removal/Replacement of Gastrostomy Tube/, replaced with reference to Elsevier 7. Clarified replacement of tube for an insertion tract > 6 weeks old a.Simple GT may be replaced at the bedside: If with an internal bumper, inform physician to request for removal alternative 8. Generalized that physician will inform nurses when GT may be used after confirmation of placement 9. Removed orders section because components are included in EPIC orders 10. Clarified dressing change section: use of split drain sponge, not regular 11. Clarified skin assessments for sites obscured by dressing to observe dressing is secured qshift and assess skin with dressing change (e.g., weekly for M Fixx or hydrocolloid dressing) 12. Changed checking of gastric residual volume from 18h to q shift 13. Changed to obtain order for specific flush protocol for residents with fluid restrictions 14. Clarified labeling of syringe with name and date,
Nursing	J 1.0	Medication Administration	1. Removed #11 - Narcotic administration will have two LN check and document in HER 2. Revised Self-Administration section with updated language from the regulations in addition to the previous update for herbal supplements.

Deletion Nursing Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	C 3.0	Obtaining Nursing Forms, Medical Records Appendix 1: Obtaining Nursing Documentation Forms, Medical Records, and Chart Order	Request to delete Appendix 1: Obtaining Nursing Documentation Forms, Medical Records, and Chart Order
Nursing	E 6.0	Total Parenteral Nutrition	Request to delete and move to HWPP
Nursing	D5 3.0	Cast Care	Request to delete and use Elsevier

Revised Hospital-wide Policies and Procedures

USE OF PSYCHOTROPIC MEDICATIONS

PHILOSOPHY:

LHH shall continuously monitor each resident's drug/medication regimen to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.

POLICY:

1. Informed consent shall be obtained as described in MSPP D01-05 Psychotropic Medication Management, regardless of indication for use.

~~1.~~2. Resident Care Team (RCT) shall ensure that each resident's drug regimen shall be free from unnecessary psychotropic[1] medication and conform to State and Federal regulations.

~~2.~~3. Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication.

~~3.~~4. Residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

~~4.~~5. Residents shall not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed, specific condition that is documented in the clinical record. PRN use of psychotropic medications shall be limited as follows:

a. PRN non-antipsychotic medications shall be limited to 14 days unless a longer time frame is deemed appropriate by a physician and there is documentation of their rationale and the duration of the PRN order in the medical record.

b. PRN antipsychotic medications shall be limited to 14 days and may not be renewed unless the attending physician evaluates the resident for the appropriateness of that medication.

~~5.~~6. Psychotropic medications shall never be used for reasons of staff convenience and/or to discipline a resident.

~~6.~~7. Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue or taper the dosage of these drugs.

[1] Also known as psychiatric medication.

~~7.~~8. Providers will document specific observable and quantifiable target behaviors to be monitored in a target symptom order for any resident on psychotropic medications ~~except medications for sleep~~.

~~8.~~9. Target symptoms are not required when psychotropic medications are used to treat other medical conditions such as seizures, spastic disorders, hiccups, terminal delirium, pain, etc.

~~9.~~10. The licensed nurse is responsible for monitoring the specific target behaviors and documenting in the electronic health record (EHR).

~~10.~~11. The provider is responsible reviewing the target symptom monitoring to inform their assessment of the effectiveness of the psychotropic regimen.

~~11.~~12. Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).

~~12. Informed consent shall be obtained as described in MSPP D01-05 Psychotropic Medication Management~~

~~13. Consent for psychotropic medication need not be obtained when psychotropic medications are used to treat medical conditions, such as seizures, spastic disorders, hiccups, terminal delirium, and pain.~~

PURPOSE:

To assure that the use of psychotropic medications is appropriate and justified and that residents and their families or surrogate decision makers (SDMs) are informed about, and consent to utilization of psychotropic medications.

DEFINITION:

"Psychotropic drug": any drug that affects brain activities associated with mental processes and behavior. These include, but are not limited to, anti-anxiety agents, anti-depressants, anti-psychotics, anti-manic drugs, and sedative-hypnotics.

"Adverse consequence": is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition, or functional or psychosocial status.

"Behavioral Interventions": individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being.

"Anti-psychotic medication": any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders, per Title of California Regulations, Section 850-857.

PROCEDURE:

1. **Initiation**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure 1, prior to initiating a resident on psychotropic medication(s).

2. **Informed Consent**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure 3, for obtaining informed consent.

3. **Emergency use of psychotropic medications**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure 5, ~~and Nursing Protocol for using Psychotropic Medications for Emergency Situation for emergency use of psychotropic medications.~~ Standard Work on Emergent Medications.

4. **Monitoring and Documentation**
   Refer to Nursing J-02.5 Monitoring Behavior & the Effects of Psychoactive Medications, MSPP D01-05 Psychotropic Medication Management, procedure 1, and Pharmacy Services 6.00 Clinical Pharmacy 06.01.01 Psychotropic Medication Procedure for monitoring residents who are on psychotropic medication(s) and documentation procedures.

ATTACHMENT:
Attachment A: Informed Consent for Psychiatric/Psychotropic Medications

REFERENCE:
~~MSPP C02-01 Patient's Informed Consent for Treatment and Operation~~
MSPP D01-05 Psychoactive Medications
~~NPP J2.0 Consent for Psychoactive Medications Used to Modify Behavior~~
NPP J2.5 Monitoring Behavior and the Effects of Psychoactive Medications
Pharmaceutical Services Policy and Procedure 06.01.00 Medication Regimen Review
Pharmaceutical Services Policy and Procedure 06.01.01 Psychotropic Medication
Appendix PP of the Long Term Care State Operations Manual
Nursing Standard Work on Emergent Medications

Revised: 12/09/25, 13/05/28, 19/05/14, 21/09/14, 23/01/09 (Year/Month/Day)
Original adoption: 12/05/22

WIRELESS ~~REFRIGERATION AND WARMING~~ TEMPERATURE MONITORING SYSTEM

POLICY:

1. **All blanket warmers, medication, nutrition and specimen related refrigerators or freezers, and medication rooms will be part of the wireless temperature monitoring system.**

   a. Any new refrigerator, freezer or blanket warmer put into service, will have the wireless temperature sensor installed when the refrigerator is delivered.

   b. Any refrigerator or freezer that is replaced will need to have maintenance remove the wireless temperature sensor from the old appliance and installed into the new appliance.

   c. If a medication refrigerator or freezer is sent to maintenance for repair, the manager or designee of the area will assure that all medications are moved to a medication refrigerator or freezer that is monitored by the wireless temperature monitoring system.

   d. The manager or designee will need to assure that the temperature is within defined limits before placing medications into the refrigerator or freezer.

2. **All refrigerators ~~and~~, freezers and medication rooms will have designated alarm settings** that will trigger if outside the acceptable range listed below.

   a. Medication refrigerator (36 – 46 degrees F), freezer (< 5 degrees F), medication room (68 – 77 degrees F)

   b. Nutrition refrigerator (33 – 41 degrees F), freezer (minus 30 – 0 degrees F)

   c. Specimen refrigerator (36 – 46 degrees F), freezer (minus 30 – 14 degrees F)

   d. Blanket warmer (no lower limit – 135 degrees F) normal operating temperature set no higher than 130 degrees F

3. **All refrigerators, freezers, medication rooms and blanket warmers will have alarms routed to a designated individual for responses to alarms. This will be by pager with an e-mail/page going to the designated staff person.**

   a. Departments are responsible to assign the wireless refrigerator, freezer, medication room and blanket warmer temperature monitoring system pager alarms to designated individuals.

b. Each department is responsible for notifying Facility Services of changes in the wireless refrigerator, freezer, medication room temperature, or blanket warmer monitoring system access list.

c. For Departments that do not operate 24/7, the wireless refrigerator, freezer, medication room or blanket warmer temperature monitoring system pager alarms will be automatically routed to nursing operations after hours.

PURPOSE:

1. To automate (using radio frequency) refrigerator, freezer, medication room and blanket warmer temperature monitoring and recording.

2. To notify staff via pager of temperature out of range that need corrective action to assure appropriate storage of refrigerated items and meet regulatory requirements.

PROCEDURE:

1. Calibration of System

a. Facilities will calibrate the system on a yearly basis.

2. Documentation for Temperature Monitoring

a. The designated department will check the refrigerator/freezer sensor readings twice a day. The check will be documented as initials on a temperature monitoring log maintained in the department. The first check each morning will include a review of the "Alerts by Day" report for the previous 24 hours or longer if the department is not open 7 days/week.

Department Responsibility

i. Pharmacy all medication storage refrigerators/freezers and medication rooms

ii. Nutrition services all nourishment refrigerators/freezers

iii. Lab all specimen storage refrigerators/freezers

iv. Nursing will document twice daily the status of refrigerators, freezers, and blanket warmers. The response to alarms for refrigerators and freezers is described in Section 3 and the alarm response for blanket warmers is described in Section 4. Performing off-hour procedures is described in Section 5.

3. Alarm Responses (~~Refrigerators or Freezers~~Refrigerators, Freezers or medication rooms)

a. When a designated individual receives a "refrigerator or freezer out of range alarm" it will be indicative of the temperature being out of range for 120 minutes and must be responded to within 30 minutes.

b. After 30 minutes of no response to the alarm, the initial alarm will be resent.

c. After 45 minutes of no response to the alarm, the escalation notifications in place will be activated.

d. The responsible individual will go to the identified refrigerator or freezer and problem-solve the reason for an out-of-range alarm (i.e. door open, thermostat needs adjustment, motor broken). The actions taken (e.g. to shut the door, reset the thermostat to the correct setting, call facilities) will be documented in the "Corrective Action/Notes" section of the alarm response.

   i. If the refrigerator/freezer does not return to the designated range notify Facility Services and document this action in the "Corrective Action/Notes" section of the alarm response.

e. If a refrigerator or freezer used for medication storage or a medication room is out of range, the Pharmacy should be contacted to assist with determining if drug stability has been affected by temperature changes during the out-of-range length of time. Drugs whose stability may have been affected by a temperature change should be segregated and placed into a refrigerator or freezer with the proper storage temperature until it is known whether the drugs are still suitable for patient use.

   i. Document the notification of Pharmacy to assess drug stability in the "Corrective Action/Notes" section of wireless refrigerator and freezer temperature monitoring system.

4. Alarm Responses (Blanket Warmer)

a. When the charge nurse receives an alert via page indicating "blanket warmer out of range", the charge nurse will respond by checking the blanket warmer for possible causes and adjusting the temperature when needed. Document action on Temp Trak.

b. After 30 minutes of no response to the alarm, the initial alarm will be resent to the charge nurse and nursing operations.

c. To eliminate the alarm sounding off the equipment open the door, turn the thermostat dial down to 130 degrees F and wait for the thermostat to read 130 degrees F. Then, close the door.

5. Off-Hours

For areas that do not operate 24/7, alarms will be responded to by the watch engineer and nursing operations.

a. For Departments not operating 24/7, the staff will review temperature logs as part of their opening procedures. Nursing operations will notify department of off hour alarms.

b. Alarms for refrigerators or freezers located inside the pharmacy during off hours, nursing operations will contact the on-call pharmacist to assess the alarm.

REFERENCE:
NPP D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerator via TempTrak & Cleanliness of Refrigerators
NPP D9 9.0 Appendix 2 – Refrigerator TempTrak Brief Reference Guide
NPP M 11.0 Warmer Protocol

REFERENCE:
None.

Revised: 14/11/25, 16/01/12, 21/09/14. 23/02/15 (Year/Month/Day)
Original adoption: 11/11/29

APPENDIX A:

Temp Trak Pager List

Location	First Page Number	Unit Med and Nourishment Refrigerators	Escalation M-F 0800-1700 After 30 minutes if no response	Escalation on Nights/Weekends/Holiday
PM pager	**415-327-8713**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
South 6 pager	**415-327-8712**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
South ~~5 pager~~5 pager	**415-327-8711**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
South ~~4 pager~~4 pager	**415-327-8710**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
South 3 pager	**415-327-8709**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
South 2 pager	**415-327-8708**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North 6 pager	**415-327-8707**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North 5 pager	**415-327-8706**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North 4 pager	**415-327-8705**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North ~~3 pager~~3 pager	**415-327-8704**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North 2 pager	**415-327-8703**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
North 1 pager	**415-327-8702**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
NM pager	**415-327-8701**	x	(415) 327-8019 Nurse Manager	(415) 327-~~8023~~1902 Nursing Ops
Pharmacy ~~TempTrak~~ Pager	~~(415)327-1150;~~ (415)327-2005	All Med Storage Refrigerators/Freezers/ Med Rooms		(415) 327-~~8023~~1902 Nursing Ops (Call on call RPh) and Facilities

Clinic	(415)327-11180333	Clinic Refrigerators		(415) 327-80231902 Nursing Ops and Facilities
Lab	(415)327-4904	All Specimen Refrigerators		(415) 327-80231902 Nursing Ops and Facilities
Dietary	(415) 327-11842531; (415) 327-1181; (415) 327-11251805; (415)327-1981; (415)327-1980; (415)327-1995; (415)327-0429; (415)327-1994; (415)327-1876	All Nourishment Refrigerators/Freezers in kitchens		(415) 327-80231902 Nursing Ops and Facilities
Facilities	(415) 327-7755370-9692;(415) 370-8259	All Refrigerators		Facilities
Nursing Ops	(415) 327-80231902	All Refrigerators after hours		Facilities

Revised Facility Policies and Procedures

PORTABLE FIRE EXTINGUISHER INSPECTIONS AND MAINTENANCE

POLICY: In accordance with NFPA 10 a certified extinguisher company shall inspect all portable fire extinguishers at least annually and shall maintain them as necessary; the Safety Engineer or designee shall inspect all portable fire extinguishers monthly at no more than a 31-day interval and assure that they are clearly labeled.

PURPOSE: To assure that every portable fire extinguisher will be easily accessible and function properly during a fire emergency and during periodic tests.

PROCEDURE:

A. The Safety Engineer or designee shall inspect all portable fire extinguishers monthly at no more than a 31-day interval and shall date and initial each tag at the time of inspection. All NFPA 10 inspection criteria shall be observed.

B. The Safety Engineer shall complete and maintain record of each inspection.

C. The Safety Engineer shall assure that a certified extinguisher company inspects all portable for extinguishers at least annually (at not more than 1-year) and performs maintenance.

D. The Director of Facility Services periodically shall report status of inspections to the PIPS Committee.

EFFECTIVE DATE: 5-18-97,

Revised January 2023 LS

Revised Nursing Policies and Procedures

RESIDENT ACTIVITIES OF DAILY LIVING

POLICY:

1. Registered Nurse assesses the functional ability of each resident to perform the activities of daily living (ADL) upon admission, quarterly, annually and when a significant change in condition occurs.

2. The Licensed Nurse in collaboration with the resident care team (RCT) develops a plan of care to meet the resident's ADL needs, while promoting as much functional independence as possible.

3. All nursing staff except Home Health Aides may be assigned to provide assistance with ADL care.

4. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

~~4.~~

5. Non-medicated personal hygiene items may be stored at the bedside in a bag and placed in a closed drawer. Non- medicated personal oral hygiene items must be kept in another bag separate from topical personal hygiene items. (Refer to B 6.0 Items Allowed at The Bedside)

6. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

PURPOSE:

1. To promote resident comfort and hygiene.

2. A program of ADLs is provided to residents to maintain or prevent decrease in functional status and/or return resident to their highest level of independence.

PROCEDURE:

A. Preparation of Resident – The resident's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's dignity, privacy, safety and confidentiality.

1. Gather all anticipated hygiene and grooming supplies before approaching the resident.
2. Knock before entering the room and introduce yourself to the resident.
3. Explain care activities to the resident and engage their participation.
4. Maintain privacy during care and keep the resident warm and covered as much as possible during care.
5. Engage the resident in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aides as needed.
6. The individualized resident care plan is followed by all nursing staff, and updated as needed.

B. Activities of Daily Living – Activities of daily living are tasks related to personal care: bed mobility, ambulation, locomotion, dressing, eating, toileting, eating, transferring, personal hygiene, and bathing. Basic nursing care procedures are to be followed utilizing Mosby's Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.

1. **Personal Hygiene**

    a. Individualized restorative nursing programs for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident's abilities.
    b. Resident is positioned at the sink or bedside with all necessary equipment within reach.
    c. Equipment and instruction provided to maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
    d. Skin care routinely includes teaching and assisting the resident to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.

2. **Dressing**

    a. Residents are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
    b. Residents are encouraged to choose their clothing.
    c. Adaptive equipment is provided and used as needed.
    d. Alternative methods of dressing are taught as needed.
    e. Occupational therapy consultation is requested as needed through the primary physician.

3. **Eating**

    a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
    b. Residents are encouraged to eat preferably in the dining room.
    c. Residents are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
    d. Specialized feeding plans, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
    e. Dentures and adaptive devices are provided and utilized as needed.
    f. Oral care after each meal is strongly encouraged. When residents do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

4. **Toilet Use**

    a. Cognizant residents are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing caregiver may reinforce this information within their scope of practice and related policies.
    b. Privacy and comfort during elimination must be maintained.
    c. When placing resident on the toilet or commode, the employee is to ensure resident safety until resident is ready to leave, then assist resident to stand and walk or transfer as needed.
    d. Incontinent residents are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.

e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.
f. Residents with indwelling urinary catheters receive perineal care each shift and as needed.

5. **Transfer, Ambulation**

a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing.
b. Follow basic safety principles for transfer and ambulation such as coaching the resident to rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.
c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the care plan and is to be followed.

6. **Bed Mobility**

a. Nursing standards for every two-hour turning/ repositioning of dependent residents are to be followed.
b. Exceptions to the above-noted standard related to resident preferences not to be disturbed during hours of sleep are to be discussed with the Resident Care Team (RCT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.
c. Resident may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident has limited weight bearing status.

C. Organization of Resident Care Assignments

1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.

2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents on the neighborhood to let each resident know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.

a. Rounds are to include the resident's rooms, bathrooms, and other areas on the neighborhood where residents are residing.
b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.
c. To ensure safety, reassure dependent residents to request for assistance to move or get up.
d. Before beginning a lengthy procedure with a resident, it is usually appropriate to check on the other residents first to promote regular monitoring of residents.

3. **Time preferences:** Check in with residents for preference of bathing time. Refusals of care or resident requests that place an undue burden on the staff are negotiated to achieve a reasonable compromise with RCT members' support as needed.

D. Environment of Care

1. **Personal supplies**- Refer to B 6.0 Items Allowed At The Bedside. Personal supplies or items may include, non-medicated personal hygiene items, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, ~~electric shavers,~~ bedpans and urinals. Electric shavers and personal razors are not allowed to be kept at the bedside. These items shall be stored in a locked drawer in the unit after each resident's use for safety.~~,~~

    a. Items such as oral hygiene equipment, washbasins, and adaptive eating utensils are labeled with the resident's initials, rinsed after each use, allowed to air dry and returned to resident's bedside.
    b. Clean urinal, bedpan, and bedside commode with facility-approved disinfectant.
    c. Clean bedpans or urinals may be kept in the lower drawer of bedside cabinet. If resident prefers, clean urinals may be kept within reach of resident.
    d. Oral hygiene equipment, bedpans or urinals are changed as needed.

2. **Combs and brushes** are to have hair removed and are to be cleaned as needed and replaced when broken or worn.

3. **Resident's area** is to be kept orderly and clean including:

    a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
    b. Spills or unclean floors are brought to the attention of EVS staff. Nursing shall clean the spill, then EVS shall mop and disinfect spill area.
    c. Resident preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents unnecessarily, for example:

        i. Provide containers for non-perishable food.
        ii. Offer regular snacks and provide a realistic means for able residents to obtain nutritious snacks independently.
        iii. Offer assistance in tidying up with the resident/family/responsible party.
        iv. Offer assistance in prioritizing items if resident feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.
        v. Communicate regularly with residents regarding which items they value so that items are not inadvertently discarded as trash.
        vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are **not** permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents / Visitors.)

4. Resident's **personal clothing** is laundered in the neighborhood or on site. See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.

5. **Linen** and other **personal care items** are not to be brought to another resident's area once such items are brought into a resident's room.

a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
b. The soiled linen hamper is to be covered at all times and is to be emptied before it is more than ¾ full or when it is malodorous.
c. Linens carts are distributed to each neighborhood by laundry staff once a day.
d. Gather supplies needed for each resident prior to beginning care.

E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.

2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents.

3. IADL programming that specifically supports resident comfort and hygiene and may be provided in whole or in part by nursing may include:

    a. Manicures
    b. Make-up application
    c. Walking, including walk to dine programs
    d. Exercise programs
    e. Practice folding garments or linen
    f. Grooming activities
    g. Off neighborhood visits, strolls, and activities

F. Reporting and/or Documentation

1. **Electronic Health Record (EHR):)**
   CNA or PCA: Record level of function for each ADL. Report any physical or behavioral changes to the charge nurse and document.

2. Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident ADLs and additional entries and document resident status on the weekly summary, as directed by the documentation policy.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure

22-03 Resident Rights

Nursing Policy and Procedure
- B 5.0 Color Codes –Resident Identification
- B 6.0 Items Allowed at the Bedside
- C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
- C 3.2 Documentation of Resident Care Nursing Assistant
- E 1.0 Oral Management of Nutritional Needs
- Section F: Elimination Procedures

Facility Services Policy and Procedure
- EM-6 Laundry Equipment Repairs and Clean Up

Revised: 2005/12, 2006/01, 2009/09, 2010/04, 2016/07, 2019/03/12; 2022/11/08

Reviewed: 2019/03/12; 2022/11/08

Approved: 2022/11/08

ASSISTING RESIDENTS DURING MEALTIME

POLICY:

1. Nursing staff will assist the resident for meals including hand hygiene prior to and after meals and utilize appropriate clothing protectors as needed for a safe, sanitary, and dignified dining experience.

2. The facility will provide table service to all residents who desire it, served at tables of appropriate height when clinically appropriate to do so.

3. Nursing will provide residents with adaptive devices, dentures, eyeglasses, and hearing aids, if needed, during mealtime.

4. Nursing staff will verify that resident's meal tray matches menu ticket order for name, meal preference, content, and consistency.

5. Nursing staff will offer residents options for neighborhood dining preference, ensure meal preferences are offered and provide a nutritionally-based, appetizing meal three times per day plus snacks following nationally recognized food standards.

6. During periods of respiratory infectious outbreaks, nursing will plan for social distancing between residents and other necessary infection prevention practices when meals are served in communal dining areas, and/or provide for in-room dining when situations warrant the need to reduce the high risk for transmission.

PURPOSE:

To provide staff guidance for a safe, sanitary and dignified meal service for residents and to provide appropriate assistance with meal service as needed, including the use of assistive devices to promote independence in eating.

PROCEDURE:

A. Preparation

1. Prepare for meals by making sure the resident's hands and face are washed. Offer clothing protector to all residents each time. Provide opportunities for hand hygiene prior to meal service.

2. Orient the resident, as needed, that it is meal time and provide appropriate clothing protectors. Assist resident to dining area of choice, if applicable.

3. Adjust bedside table to proper height for in-room dining and ensure proper lighting and safety.

4. Nursing staff will disinfect tabletop using facility-approved disinfectant and allow to air dry, prior to meal service.

5. Nursing staff will provide for safety measures when serving hot liquids including coffee, tea or hot soups. Notify the resident of the location of the hot beverage/liquid on the tray.

6. Staff who are feeding or supervising residents designated at-risk for aspiration are responsible for reviewing and complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

7. Position the food tray according to resident's ability to see the contents, use utensils, and swallow (e.g., food in the line of vision, and place utensils on the functional side).

8. Assist the resident to open cartons, remove coverings and to cut up food as necessary. Maintain resident dignity by not automatically cutting residents food up or opening food items without requesting permission from the resident first to do so first.

9. Set up adaptive equipment for residents such as scoop bowls, braces, looped spoon handles etc. Allow and encourage the resident to be as independent as possible during meal time.

10. Inform visually impaired residents of menu content and placement of food on their plate or tray. Review plate contents using a clock face for orientation, even if the resident is being fed by staff. For example, "Your chicken is located at 12:00, mashed potatoes at 3:00 and broccoli is at 7:00". Informed resident of location of liquids, both hot and cold.

11. When residents are out of bed during mealtime, if possible, arrange a group to allow residents the opportunity for socialization. Grouping will allow the staff to give close attention to several residents while assisting them with their food. By feeding one resident a spoonful, and successively rotating turns among the residents performing hand hygiene between residents, each resident is allowed time to chew the food without hurrying.

B. Positioning

1. Positioning in chair for communal dining:

   a. Resident should sit upright in a comfortable position utilizing good body alignment to minimize aspiration.

   b. Chairs should be stable and have arm rests to prevent sliding or falling. Residents who cannot hold themselves upright should not be placed in a regular chair. Consult with therapy for appropriate assistive chairs.

   c. Staff who are providing feeding assistance will position themselves directly across from the resident in a seated position at eye-level.

2. Positioning in bed for in-room dining:

   a. Elevate the head of the bed to the highest comfortable position for the resident but minimally 45 degrees, to position the resident upright to aid in swallowing and reduce aspiration.

      i. If needed, support resident's head with a pillow to keep the head in good alignment, positioned just slightly forward, chin not resting on the chest and head not tilted backward.

      ii. Pillows may be used to support the resident's arms as needed.

      iii. Use support pillows to maintain good alignment, with particular attention to weaker sides from strokes or other disabilities and for stability.

iv. For residents with aspiration precautions and/or enteral feeding, leave head of the bed elevated 45 degrees or more for at least one hour (1 hour) after meals.

C. Assisting the Resident to Eat

1. Prepare the food from the tray for eating:

   a. Check with resident if food temperature is comfortable as their preference.

   b. Do not mix foods together unless the resident requests such as mixing peas and mashed potatoes for example, or eggs and hot cereal.

   c. Provide opportunities for independence and dignity for self-care while eating, as appropriate such as holding their own bread or cracker, for example.

   d. Do not overfill drinking containers; provide sipping lids as appropriate but do not assume every resident needs a drinking lid.

   e. Open all containers if the resident cannot, even if resident may not eat the contents.

   f. Cut up food into bite-size pieces if the resident requires or requests. Residents may prefer to not have food cut up by others.

   g. Ordered thickeners are to be used only as directed for those at high risk for aspiration.

2. Offer a sip or two of liquid first to moisten resident's mouth before feeding to stimulate secretions and swallowing.

3. Put a small amount of food in the mouth at one time in the area of the mouth where resident has the best muscle control and taste perception to promote safe swallowing. Allow enough time for chewing. Do not rush the resident.

4. Watch to see that food or fluids are swallowed before offering more.

5. Alternate food and fluids, offering food in the order the resident prefers.

6. Feeding assistants should be aware of residents who may not swallow each bite ("pocketing"). If this is occurring, slow down the process and encourage resident to chew and swallow. Staff should seek assistance from nursing staff to alert speech therapist for individualized guidance.

7. Clean away food or liquid from the face as needed to promote a dignified experience. Clean nasal secretions away immediately using a tissue and preform hand hygiene.

D. After the Meal

1. Offer opportunities to clean the resident's hands and face, remove clothing protectors, and provide oral hygiene.

2. Keep resident sitting upright for at least 20 minutes after the meal. If resident must lie down, position on their side.

3. Clean any adaptive equipment that the resident used. Keep adaptive equipment at the bedside and labeled with their name.

4. Place water pitcher within resident's reach unless resident is on fluid restriction, or otherwise ordered, and encourage fluid intake between meals.

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CAHAN (California Advocates for Nursing Home Reform (2016). Nursing Home Care Standards. Food and Nutrition. http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html

CROSS REFERENCES:

Hospitalwide Policies & Procedures
26-02 Management of Dysphagia and Aspiration Risk
26-04 Resident Dining Services

Nursing Policies & Procedures
E 1.0: Oral Management of Nutritional Needs

Original: 2018/01/09

Reviewed: 2018/01/09; 2021/02/09

Approved: 2021/02/09

ENTERAL TUBE FEEDING MANAGEMENT

POLICY:

1. Enteral nutrition is instituted after careful resident assessment and if clinically indicated for:
   a. Short-term intervention for acute management of nutritional support.
   b. Last resort treatment for insufficient oral nutrition if consistent with the resident's goal of care.

2. Position is confirmed by gastrografin for any tube placement or replacement prior to initial use.

3. Routine enteral tube placement is checked by measuring external tube length and inspecting the mouth for Nasogastric Tubes:
   - upon admission and relocation
   - after placement or replacement
   - each shift~~before each intermittent feeding or daily for continuous feedings~~ and as needed
   - ~~before medication administration~~prior to accessing

4. The Licensed Nurse (LN) checks the feeding pump at the beginning of the shift to verify that the pump is functional and programmed per the order.

5. For simple balloon gastrostomy tubes (no PEG or internal bumper) that are older than 6 weeks, a trained Registered Nurse (RN) replaces the tube at least every 3 months due to the balloon failure risk and as needed (i.e., worn, dislodged or clogged), unless ordered otherwise. A foley or gastrostomy tube may be placed in the stoma to keep tract open until tube can be replaced.

6. Gastrostomy tubes less than 6 weeks old are ~~or jejunostomy tubes are~~ re-inserted by Interventional Radiology (IR) or Gastroenterologist. No attempts should be made by LHH staff to replace ~~newly placed~~ tubes less than 6 weeks old (Refer to LHHPP File # 26-03).

~~6.~~7. J-tubes are replaced by IR ~~not replaced at Laguna Honda~~, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR.

~~7.~~8. A trained RN or LVN may place and remove a nasogastric tube (NGT) as ordered. Nasointestinal tubes (weighted tubes) are not inserted at LHH.

~~8.~~9. Tap ~~W~~water is used for medication dilution and access device flushes.

~~9.~~10. Reverse Luer lock (ENfit) devices or temporary transition adapters will be used for all enteral nutrition tubes.

PURPOSE:

To ensure safe practice associated with enteral feeding tube use, including the insertion, initial placement verification, ongoing placement verification, maintenance and discontinuation.

DEFINITIONS:

- **Enteral feeding** ("enteral nutrition" or "tube feeding") is the system of providing nutrition or medication directly into the gastrointestinal tract (stomach, duodenum, or jejunum).
- **Nasogastric Tube** ("NGT" or "NG tube") is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. NGTs are placed in residents who require enteral nutrition for up to approximately 4-6 weeks.

- **Gastrostomy Tube** ("G-tube" or "GT") is a tube that is initially placed by surgeons, interventional radiologists (IR), or gastroenterologists through the skin of the abdomen and secured in the stomach. G-tubes include balloon-type G tubes, percutaneous endoscopic gastrostomy (PEG) tubes, pigtails, mushroom tubes, and MIC tubes.
- **Jejunostomy Tube** ("J-tube") is a specialized feeding tube inserted into the jejunum of the small intestine by surgeons or interventional radiologists (IR), or gastroenterologists. ~~**J-tubes are not replaced at Laguna Honda, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR.**~~
- **Transgastric jejunal feeding tube** ("G-J tube" or "GJT") is a feeding tube that is placed through the stomach into the jejunum by surgeons or IR, and that has dual ports to access both the stomach and the small intestine.
- **External bolster** ("bumper" or "disks") prevent inward migration of percutaneous enteral access device.

PROCEDURES:

A. Insertion of NGT

A licensed nurse replaces dislodged NGTs unless ordered otherwise. ~~LVNs that have demonstrated competency may insert an NGT. Radiologic verification of tube placement shall be obtained each time a NGT is placed or replaced.~~

Procedure for Insertion and Removal of NGT:

Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).~~Refer to "Nasogastric Tube: Inserting and Verifying Placement in the Adult Patient" Skill Competency Checklist on Nursing Reference Center Plus for detailed information (see references for link).~~

~~https://search.ebscohost.com/Community.aspx?community=y&authtype=ip&ugt=723761666C76658727E665D662156E9261E327E333133403316336 23&stsug=AkyMCIkUzWydYOr9Kbs9Ci4vDyFarVDzc-pSjff7036IJGrWUTAikjQNEKGxiffp4Wkyb7hXQ6n_9WmS7sWXAa7ddcYwaq7u9Arm-V8u7bvrm5NOT3ySErcrAwB66-l7v6sesl2KlSczixDXa6WBwK9EpYKGuVCWUjzzeHo4Yw&IsAdminMobile=N&encid=22D731163C56352737763546328 53C973113376373C374C371C376C372C376C370C331~~

~~1. Educate resident about the insertion procedures in advance and ensure resident's privacy throughout the procedure. Assess the patient for the presence and/or history of nasal injuries or strictures that may hamper the procedure. Inspect the condition of the nasal and oral cavities. Evaluate for contraindications, such as recent traumatic injuries to the head, face, and neck region, elevated bleed risk, etc. and notify provider if present.~~
~~2. After Procedure~~
~~a. Once the enteral tube is inserted to the previously estimated depth, secure the enteral tube with tape. To decrease pressure on the nose, secure the tube (e.g., tape tube to the neck or cheek with micropore tape or semipermeable transparent dressing, or pin to gown).~~
~~b. Verify the tube tip placement location by x-ray.~~
~~c. Mark the tube with permanent marker or a piece of tape at the naris (exit site) to indicate the appropriate depth upon initial placement. Measure the external distance from the naris to the end of the tube.~~
~~d. Plug, cap or clamp tube.~~
~~e. Verify NGT placement before initiating feeding, connecting to suction, or administering medications by length of the tube and aspiration of gastric consents.~~
~~3. Document the procedure. Refer to section Procedure J Documentation.~~

~~**B. Removal of NGT:**~~

~~**Procedure for Removal of NGT:**~~

~~Refer to "Nasogastric Tube: Removing from the Adult Patient" Skill Competency Checklist on the Nursing Reference Center Plus for detailed information (see references for link).~~

~~https://search.ebscohost.com/Community.aspx?community=y&authtype=ip&ugt=723761666C76658727E665D662156E9261E327E3331334033163362 3&stsug=AkyMCIkUzWydYOr9Kbs9Ci4vDyFarVDzc-pSjff7036IJGrWUTAikjQNEKGxiffp4Wkyb7hXQ6n_9WmS7sWXAa7ddcYwaq7u9Arm-V8u7bvrm5NOT3ySErcrAwB66-l7v6sesl2KlSczixDXa6WBwK9EpYKGuVCWUjzzeHo4Yw&IsAdminMobile=N&encid=22D731163C56352737763546328 53C973113376373C374C371C376C372C376C370C331~~

~~1. Educate the resident about the removal procedure and ensure the resident's privacy throughout the procedure.~~
~~2. Remove Tube~~
~~a. Prior to the procedure, disconnect NGT from pump or suction tubing and irrigate the enteral tube to clear it and prevent aspiration. Clamp or plug the NGT.~~
~~b. Remove tape or securing device. To remove bridle ("bridle loop"), a nasal retention device, cut one aspect of the bridle. The bridle can be pulled through the naris along with the NGT.~~
~~c. Instruct the resident to take and hold a breath.~~
~~3. Post Procedure~~
~~a. Inspect the tube to ensure it is intact. Discard in trash can as regular waste.~~
~~b. Keep wall suction or suction machine available in case resident has emesis.~~
~~c. Clean the naris and provide mouth care.~~
~~4. Document the procedure. Refer to section Procedure J Documentation.~~

~~C.~~B. Replacement of GT, JT and GJT ~~Tube~~

1. ~~If a G-tube with an i~~nsertion tract < 7-10 days old~~: dislodges,~~ immediately notify the physician of dislodgement. This may be a medical emergency if stomach contents leak into the peritoneum. Do not attempt tube replacement because it may be accidently positioned into the peritoneum.

2. Insertion tract < 6 weeks old: ~~A dislodged gastrostomy or jejunostomy tube that is **less than 6 weeks old**~~tubes shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

3. Insertion tract > 6 weeks old~~Replacing a G-tube (insertion tract **more than six weeks old**) due to accidental expulsion or clogging~~: only simple balloon GT may be replaced at the bedside. For GTs with internal bumper, inform the physician to request for removal alternative (e.g., removal at Gastroenterology Clinic).
    a. The RN replaces ~~dislodged~~ simple balloon GTs that are dislodged or cannot be unclogged unless ordered otherwise.
    b. For expulsion, the RN will immediately insert a balloon-type gastrostomy tube of the same size or smaller to prevent stoma closure and inform the physician.
    ~~c. If the existing tube has an internal bumper, do not remove the tube in the event of clogging or dislodgement. Inform the physician to request for a removal alternative (e.g., removal at Gastroenterology Clinic).~~
    ~~d.~~c. All gastrostomy tubes reinserted or replaced at LHH will have radiologic confirmation of tube placement (e.g,~~.~~ gastrografin) prior to use.

e.d. The LHH physician will check the radiology reading prior to use of a reinserted tube and inform nurses when GT may be used. If there is a question about tube placement, or the licensed nurse is unable to reinsert/replace the GT, the tube will be reinserted in the emergency department (ED) or interventional radiology (IR). There will be direct verbal communication from the radiologist at ZSFG to the physician at LHH confirming placement prior to use of the tube and/or if any questions arise about tube placement. Refer to 26-03 Enteral Tube Nutrition.

f.e. If the resident can tolerate NGT placement, and NGT may be placed temporarily per physician order until an IR appointment is available. If an NGT cannot be placed and there is a delay in resuming enteral nutrition and medications, intravenous fluids and medications may be required.

g.f. Keep a replacement gastrostomy tube of the same size as resident's existing tube available in the neighborhood for emergency replacement. Gastrostomy tubes are available from Central Supply.

h.g. Consider tube replacement sooner than routine every 3 months, if any of the following are identified:

i. Deterioration and dysfunction of the G-tube
ii. A ruptured internal balloon
iii. Stomal tract disruption
iv. Peristomal infection that persists despite appropriate antimicrobial treatment
v. Skin excoriation
vi. Non-healing ulcer formation that will not heal despite good wound care technique

vi.h. Complete an Unusual Occurrence (UO) report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

Procedure for Replacement of the Gastrostomy Tube

Refer to "Long Shaft Gastrostomy Tube Replacement or Removal" on Elsevier for detailed information (see references for link).

Refer to "Gastrostomy Tube: Replacing" Skill Competency Checklist on the Nursing Reference Center for detailed information (see references for link).

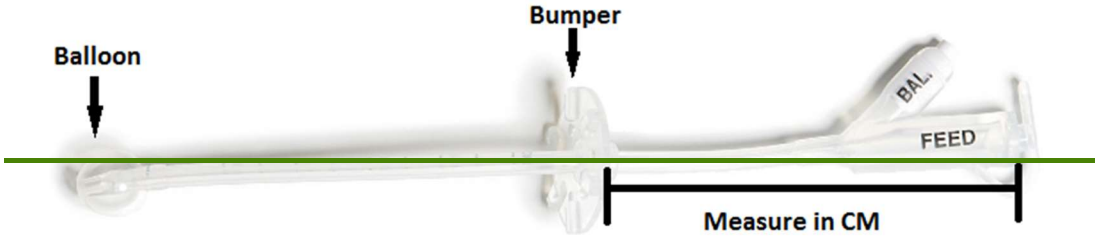
https://search.ebscohost.com/Community.aspx?community=y&authtype=ip&ugt=723761666C76658727E665D662156E9261E327E3331334033163362 3&stsug=AkyMClkUzWydYOr9Kbs9Ci4vDyFarVDzc-pSjff7036IJGrWUTAikjQNEKGxiffp4Wkyb7hXQ6n_9WmS7sWXAa7ddcYwaq7u9Arm-V8u7bvrm5NOT3ySErcrAwB66-l7v6sesl2KlSczixDXa6WBwK9EpYKGuVCWUjzzeHo4Yw&IsAdminMobile=N&encid=22D731163C56352737763546328 53C973113376373C374C371C376C372C376C370C331

1. Educate the resident about the procedure and ensure the resident's privacy throughout the procedure.

2. Remove Tube
a. Slowly rotate the G-tube and gently insert it 0.5-1 inch (1-2 cm) into the insertion tract to verify that it is not adhered to the tract. Do not attempt to remove the G-tube if the tube is adhered to the insertion tract and notify the physician.
b. If resistance is met, stop pulling and notify the physician.
c. Assess the tube to estimate the length, verify the tube is intact and discard in the trash.
d. Document the procedure. Refer to section Procedure J Documentation.

3. Insert Tube

a. **If resistance is encountered, never force the tube, as this may create a false tract or cause the stomach to separate from the insertion tract or stoma. Discontinue the G-tube insertion and notify the physician immediately.**
b. Inflate the balloon with the manufacturer's recommended amount of sterile water or specified fluid. If the resident experiences pain with balloon inflation, deflate the balloon immediately, withdraw the tube and notify the physician. Never use air or other fluids to fill the balloon. Never overfill or underfill balloon.
c. Gently pull back on the G-tube until resistance is met.
1. Mark exit site upon initial placement with a permanent marker (except low profile G tubes). MeasureMeasure the initial external tube length from insertion site at the stoma to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement. Reusable rulers are single-patient/resident use and should be disinfected before and after use.
d. Slide the GT external bumper approximately 0.5 cm from the stoma to prevent tube migration. If GT does not have an external bumper, use tape or stabilization device to position the balloon against the internal abdominal wall, and prevent migration, dislodgement or excessive traction.



e. Slide the external bumper of the G-tube approximately 0.5 in (1 cm) from the stoma to prevent tube migration and allow for slight in-and-out play of tube. If the gastrostomy does not have an external bumper, tape the tubing securely and/or use an external tube stabilization device so that the balloon is against the internal abdominal wall.

Note: Adequate skin-level stabilization of the tube is necessary to prevent: (1) lateral movement in the tube at skin level and (2) tube migration (in and out movements). Lateral movement of the tube contributes to leakage of gastric or intestinal contents onto the skin by eroding the tissue along the tract.

2.
f. Apply and tape a 4x4 drainage/split gauze or drainage sponge over the external bumper as needed (e.g., drainage present). If skin is irritated, a hydrocolloid dressing may be applied directly to the skin, underneath the external bumper to protect the skin.

4. Post Procedure
a. Notify physician of replacement and request verification with radiography and gastrografin. Do not administer anything through the tube until tube placement has been verified.
b. Complete an Unusual Occurrence (UO) report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

5. Document the procedure. Refer to section Procedure J Documentation.

D.C. Administration of Formula Feeding

1. Types of Enteral Nutritional Support:

a. **Closed System**~~:~~ ~~is used for enteral nutritional support when products are available~~formula comes in pre-filled closed containers. Closed systems are preferred due to reduced opportunity for contamination.
   i. L~~Closed enteral containers must be l~~abel~~ed~~ the container with the resident name, bed number, rate, date and time container is hung. The label~~ed date and time~~ on the container also applies to the tubing since both are one closed system.
   ii. ~~Closed enteral containers will be~~Only spike containers~~d only~~ once with a new tubing set. Tubing sets are never ~~to be~~ re-used and are~~will be~~ discarded ~~along~~ with the used container.
   iii. Shake enteral containers well prior to spiking and occasionally during hanging if settling is noticed.
   iv. C~~losed enteral c~~ontainers and ~~attached~~ tubing are discarded when the container is empty, OR within 24 hours after closed enteral container is hung.

b. **Open System**~~: is used for enteral nutritional support when products are not available in pre-filled closed containers. Open systems require~~ nutritional products are ~~to be~~ transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing.
   i. L~~Open enteral bags must be l~~abeled the enteral bag with the resident's name, bed number, formula, rate, date and time the bag is hung. The ~~date and time~~ label on the bag also apply to the tubing as both are one system.
   ii. Open enteral bags used for formula must be discarded after each use.
   iii. Open enteral bags used solely for water must be discarded within 24 hours after they are initially hung.

Refer to Appendix 1 for Preparation for Enteral Nutritional Support – Closed and Open System.

2. E~~A~~ll ~~e~~nteral tube ~~feeding~~care ~~orders~~ protocol~~will include~~: Refer to Appendix 2

~~a. Enteral Tube care per protocol: Protocol includes:~~
a. D~~d~~aily stoma care and ~~dressing changes~~ as needed~~and stoma care or as needed for GT, JT and GJT~~.
   i. Observe if GT external bumper approximately 0.5 cm from the stoma to prevent external pressure (i.e., buried bumper) or inward tube migration, which can cause leaking of gastric contents through the stoma.
   ii. Fit of the simple balloon GT should allow for easy rotation of the tube and permit cleaning under the bumper. **JT and GJT should not be rotated**.
   iii. For insertion tract < 7-10 days old, stabilize tube with one hand while cleaning skin for the first 7-10 days after initial insertion.
   iv. If GT without a bumper, use a stabilization device (i.e., Statlock or M Fixx) to secure/anchor the tube and prevent excessive tension to the exterior portion of the tube.
b. Dressing changes
   i. A 4x4 split drain sponge may be over the external bumper as needed (e.g., drainage present) and changed daily.
   ii. If the skin is irritated, a moisture barrier cream or a hydrocolloid dressing may be applied under the external bumper to protect the skin and changed as ordered.
   iii. Refer to "Feeding Tubes: PEG, Gastrostomy, and Jejunostomy Care" on Elsevier for detailed information (see references for link).

~~b.~~

~~c.~~ S~~s~~kin assessments ~~daily~~very shift skin for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage. If obscured by dressing, observe if dressing is secure every shift and assess skin with dressing change (ex: daily for

split drain sponge dressing, weekly for hydrocolloid dressing or securement device, such as M Fixx). Notify physician for any signs of skin breakdown.

c.

~~d. assessments every shift for site/dressing and patency~~

d. Eenteral tube length measurements every shift, prior to accessing, after admission or relocation, and as needed. For NGT, inspect the back of the mouth for coiling of tube.

e. Check gastric residual volume (GRV) every shift unless specified by order. Schedule the GRV checks prior to initiating intermittent formula or evenly spaced for continuous formula.

f. Flush enteral tube with a minimum of 30 mL of water using a 60 mL syringe at a minimum of once per shift, before and after intermittent feedings, before a paused feeding is resumed, after GRV measurements, and as needed. Obtain a flush order for patients/residents with fluid restrictions. For medication administration flush protocol, refer to NPP J 1.0 Medication Administration.

~~e.~~ Notify the physician for compromised feeding tube integrity or patency issues.

g.

~~i. simple GT replacements every 3 months or as needed for dysfunction~~

~~f.~~ Change the storage container and enteral syringes daily on AM shift. Label syringe (name and date), rinse with water after use, and store syringe at the bedside in clean, labeled (name and date), dry container or storage bag.

h.

~~g.~~a. ~~Change Lopez valve weekly if used~~

i. Change all closed system tube feeding containers and bags/tubing daily on AM shift using clean technique, even if bottle is not empty or expired. Change open system bags used solely for water on AM shift. Discard open system formula bags after each use.

j. Change Lopez valve weekly if used

~~ii.~~ Simple balloon GT replacements every 3 months, as needed for dysfunction, as ordered

k.

~~h.~~ NGT replacement every 64 weeks, ~~or~~ as needed for dysfunction, or as ordered

l.

m. Relocate NGT position within same nostril weekly to prevent pressure on the same site in the nostril and skin breakdown

n. Trace tubes back to their origins to prevent misconnections and ensure lines are secure prior to connections.

~~iii.~~o. Notify the Nutrition Services diet office for any new enteral diet orders or changes in formula or calories.

~~Check gastric residuals (parameters and frequency if other than q8 hours).~~

~~i. Free Water (volume and frequency)~~

~~j. Elevate HOB (parameters)~~

~~k. Intake and output – Strict~~

~~l. Weigh patient (frequency)~~

~~m. LHH Adult Diet Tube Feeding NPO (enteral only diet) or LHH Adult Diet (enteral and oral diet)~~

~~n. LHH Enteral/Tube Feeding Orders (aka enteral):~~

~~i. Route of Administration~~

~~ii. Formulary (formula and caloric value)~~

~~iii. Rate (mL/hr), Run time (hrs/day) and total volume if continuous. Jejunostomies require continuous infusion of nutritional supplements or water rather than bolus feedings.~~

~~iv. Volume (mL), Administered over (hrs) and Frequency if intermittent~~

~~v. Amount and frequency of free water administration through the enteral tube.~~

i. Water flush per protocol or other (e.g., frequency, volume, etc.): Protocol for flushing the enteral tube with a minimum of 30 mL of water (15 mL if fluids are restricted or per physician order) at a minimum of once a shift, every 4-6 hours continuous feedings, before and after intermittent feedings, before a paused feeding is resumed, and before and after gastric residual volume (GRV) measurements. For medication administration flush protocol, refer to NPP J 1.0 Medication Administration for flush protocol.

For any new enteral diet orders or changes in formula or calories, the Nurse will notify the Nutrition Services diet office.

3. Positioning

a. Assess Risk of aspiration risk should be assessed individually and implement appropriate interventions implemented, such as proper positioning.
b. ETo decrease the risk of aspiration or reflux, elevate the resident's head of the bed (HOB) to a minimum of 30 degrees prior to starting formula feeding, during, feeding and for 30-60 minutes after feeding unless otherwise ordered by physician. If theit is necessary to lower the head of bed (HOB needs to be lowered) for a procedure (i.e., linen changes or incontinence care), feedings should only be stopped for the duration of the procedure and restarted with HOB re-elevated as soon as procedure is completed.
    i. If the In residents who have has difficulty clearing secretions, it may be necessary to clear secretions (e.g., oral suctioning with order) regularly or prior to lowering of the HOB.
    ii. If on bedrest, may limit HOB elevation to 30 degrees and avoid positioning directly on a pressure ulcer/injury.

4. Infection Control

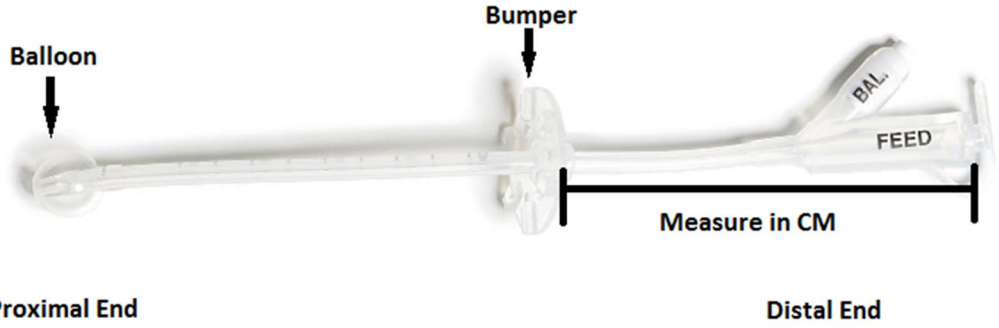
a. Examine and clean the insertion site daily to identify, lessen or resolve possible skin irritation and local infection.
b. Cover the end of the enteral tube with a clean cap for any disconnection, such as when the feeding is stopped and the distal end of the delivery device is disconnected as for nocturnal or gravity bolus feeding. Use aseptic technique when setting up and connecting the feeding administration set and related equipment. For example, use a small clean towel under the resident feeding tube connection to facilitate a clean area prior to working with the tube.
c. Inspect the stopcock ("Lopez valve") prior to each use for signs of wear (i.e., leakage or cracks) and replace if there is visible wear. Change the Lopez valve weekly.
d. After using a syringe, store syringe by the bedside in clean, labeled (name and date), dry container or storage bag to decrease the risk of microbial growth. (See Medication Administration – Appendix IV)
e. The syringe should be labeled with the resident's name and date opened, and rinsed with warm water after each use.
f. Dispose of the syringe and storage container within 24 hours.
g. Provide personal, skin, oral and nasal care to the resident. Oral care should include teeth, gums and tongue.
h. Feeding pumps are dedicated equipment (used for only one resident) and must be cleaned at least daily or as needed (i.e., visibly soiled).

5.4. Checking Enteral Tube for Correct Placement

Enteral tube placement is checked at the bedside via external tube length. Auscultation should not be used to verify tube placement. When verifying tube placement, the nurse should use clinical judgement if concerned about migration to ensure safe patient care.

~~a. **External Length of Tubing** - Check tube length for inward or outward migration every shift, upon admission and relocation, and before each intermittent feeding, and administering medication.~~

a. ~~I~~Measure the external tube length from insertion site at the stoma/nostril to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement.



b. If NGT is in place, examine the oropharynx. External tube length does not guarantee proper position, as tubes can become coiled and or/ the tube tip can become displaced into the esophagus. If there is coiled tubing, gently remove the tubing immediately to prevent airway obstruction. Inform the physician immediately if there are questions about placement.

~~c. Auscultating over the epigastrium during air insufflation (i.e., the "whoosh" method) should not be used to verify tube placement.~~

~~d.~~c. If there is a question about the enteral tube placement, do not proceed with administration of medication or feeding until correct placement has been verified.

~~e.~~d. If a change in external tube length is observed, assess the resident for symptoms of possible dislodgement and use visualization of tube aspirate to help determine if tube has become dislocated. Do not attempt to reinsert tube if partially migrated. If in doubt of placement, notify the physician and obtain a radiograph to determine tube location. Refer to section Procedure 5~~6~~ Procedure for Gastric Residual Visualization.

~~f.~~e. Respiratory compromise (i.e., increased respiratory rate, difficulty breathing, decreased O2 saturation, or coughing) may indicate tube feeding dislodgement or intolerance.

~~g.~~f. Document the procedure. Refer to section Procedure J Documentation.

~~6.~~5. Procedure for Gastric Residual Visualization and Measurement:

Refer to "Feeding Tube: Verification of Placement" on the Elsevier (Mosby's) Clinical Skills for detailed information (see references for link).
~~https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco~~

a. Checking gastric residual volume (GRV) may be appropriate when initiating tube feedings, if dislodgement suspected, or if the resident/patient reports or displays any signs of intolerance, such as ~~or for individuals who are unable to report symptoms that indicate a feeding is not well tolerated, such as~~ bloating, nausea, vomiting, and complaints of fullness, abdominal distension or abdominal pain.
b. The technique of aspirating gastric juices for GRV checks can increase clogging.
c. Stop continuous feedings for several minutes before aspirating, measuring, and returning gastric residuals.

~~d. Draw 30 mL of air into a 60 mL enteral syringe and inject air into the tube.~~

~~e. Draw back on the syringe slowly to obtain a small amount of gastric contents. If necessary, reposition the resident to facilitate withdrawal of fluid from the tube.~~

~~f.~~d. Measure the amount of gastric aspirate and observe for changes in the volume and appearance of the aspirate.

i. If the gastric residual volume is > 250 ml or the GRV order parameters, hold the tube feeding and notify physician. Aspirate, measure, and return gastric residual every 2-4 hours until resident has exhibited the ability to empty his/her stomach, at which time tube feeding may be continued or re-started with an order.

~~g. Observe the appearance of the gastric aspirate.~~

~~i. Pleural space: Pleural space fluid is typically has a pale yellow serous appearance.~~

~~ii. Gastric: Fasting gastric fluid typically is clear and colorless, grassy green, pale yellow or brown. Aspirates from NGTs with continuous tube feeding have the appearance of curdled enteral formula.~~

~~iii. Bowel: Small bowel aspirates may be minimal and are typically bile stained (yellow) or brown colored. Negative pressure during aspiration usually indicates a tube is in the small bowel. A sharp increase in gastric residual volume may indicate displacement of a small bowel tube into the stomach.~~

~~h. Return the gastric aspirate to stomach to prevent fluid and electrolyte imbalance.~~

~~i. Flush tube with 30 mL of water (20 mL if fluids are restricted or per physician order).~~

~~j.~~e. Notify the physician if ~~unable to aspirate~~ gastric secretion volumes~~s~~ or appearance is concerning.

~~k.~~f. Document the procedure. Refer to section Procedure J Documentation.

~~7. Maintaining Patency of Enteral Tube~~

~~To keep the enteral tube patent, flush tube with 30 ml of tepid or warm water (20 ml if fluids are restricted or per physician order) with a 60 ml syringe:~~

~~a. Once a shift at a minimum~~
~~b. Before and after each intermittent feeding.~~
~~c. Every 4 to 6 hours during continuous feeding.~~
~~d. During medication administration. Refer to J 1.0 Medication Administration.~~
~~e. After withdrawing and returning gastric aspirate when checking tube placement and residual volume.~~
~~f. If feeding administration is interrupted for routine care, flush the tube to reduce the residue in the tube and decrease potential for clogging.~~
~~g. As needed to keep tube patent (e.g., small French tubes or higher fiber formulas).~~
~~h. Document the procedure. Refer to section Procedure J Documentation.~~

~~8.~~6. If Tube Occlusion Occurs

Do not use any non-facility approved devices (i.e., tube brush), cranberry juice, soda or hot water to unclog feeding tubes at the bedside.

Use a gentle back-and-forth motion with 30- or 60-mL syringe filled with water to dislodge clog or a pancreatic enzyme solution per order to dissolve clog.

Refer to “Feeding Tube: Small-bore Insertion, Care and Removal” on Elsevier for detailed information (see references for link).

~~a. If the gastrostomy tube becomes clogged:~~

~~i. Attach a 60 mL syringe to the tube and pull the plunger back to help dislodge the clog.~~

~~ii. Draw up 10 or 60 mL of warm water using a 10 ml syringe and use gentle, firm pressure to instill the fluids into the tube to clear the obstruction. If resistance is~~

~~met, the plunger of the syringe may be moved using a gentle back-and-forth motion to help loosen the clog, then clamp the tube and soak for 5 - 20 minutes to allow the warm water to penetrate the clog.~~

~~iii. It may be necessary to do the above steps several times to be successful.~~

~~iv. If unable to clear the obstruction, notify the physician.~~

~~v. Document occlusion event and any interventions and notifications in a progress note.~~

~~b. If the physician orders the following de-clogging aid:~~

~~i. Physician orders Zenpep 10,000 units and sodium bicarbonate tablets 650 mg per feeding tube once with administration instructions to crush and administer together to de-clog feeding tube.~~

~~ii. Crush the sodium bicarbonate tablet(s). Open the Zenpep capsule(s) and mix beaded contents with the sodium bicarbonate powder. Add 5-15 mL of lukewarm water to mixture and stir well. Let sit for 30 minutes.~~

~~iii. Draw up mixture into 20 mL syringe.~~

~~iv. Attach syringe to end of feeding tube.~~

~~v. Install the slurry using gentle pressure.~~

~~vi. Clamp tube with 2x2 gauze and Kelly clamp for 15-30 minutes.~~

~~vii. Draw up 30 mL of lukewarm water and instill into tube gently.~~

~~viii. If unable to flush, can repeat process for a total of 3 times.~~

~~**NOTE: Do not use any non-facility approved devices such as tube brush, to unclog feeding tubes at the bedside. Do not use cranberry juice or any kind of soda to unclog feeding tubes. The sugar content clings to the inside of the feeding tube contributing to further clogging and the low pH can curdle the formula and create gas bubbles contributing to feeding "intolerance." Using hot water can curdle the protein in the formula.**~~

~~E.~~D. NGT use as Intermittent Gastric Suction

Refer to "Nasogastric or Orogastric Tube: Insertion, Flushing~~Irrigation~~, and Removal" Elsevier Clinical Skills for detailed information (see references for link).

1. Large bore, double lumen NGTs, such as the sump tube, are the preferred tubes for gastric suction. The large lumen allows of suction of gastric contents and medication delivery. The smaller vent lumen allows for atmospheric air to be drawn into the tube and equalizes the vacuum pressure in the stomach once the contents have been emptied. This prevents the suction eyelets from adhering to and damaging the stomach lining.

~~2. For insertion of NGT, refer to section Procedure A Procedure for Insertion of NGT.~~

~~3.~~2. If using a sump tube, do not clamp the air vent, connect the tube to suction or use it for irrigation. Keep the air vent of the sump tube above the patient's stomach level.

~~4.~~3. After instilling medication and/or formula and flushing with 30 ml of water, plug the NG tube for 1-1/2 hours or as ordered, before attaching to the suction machine.

~~5.~~4. Only use low suction unless otherwise ordered.

~~6.~~5. Monitor for any signs of respiratory distress and stop suction and notify physician immediately if present.

~~7.~~6. Document any volume of fluid instilled (intake) and suctioned (output).

~~F.~~E. Administration of Medication(s) Through Enteral Tube (Refer to J 1.0 Medication Administration)

~~G.~~F. Reassessment of Enteral Feeding

1. Enteral Feeding may be held, and physician notified for possible indications listed below:
   a. Aspiration, such as vomiting, choking, coughing, frothy sputum, tachycardia, respiratory distress, or fever.
   b. Fluid and electrolyte imbalance
   c. Intolerance of feedings, using measures such as slow gastric emptying (GI motility status), assessment for abdominal distension, firmness, diarrhea and large ~~gastric residual volume (~~GRV~~)~~, feeling of fullness, or nausea that might lead to gastric reflux.
   d. Peritonitis, such as abdominal pain and/or bloating, constipation, fever, nausea, vomiting, diarrhea, weakness, dizziness, dyspnea, tachycardia, tachypnea, and inability to pass gas or feces, and dehydration. Feeding tubes can perforate the stomach or small intestine, and result in peritonitis.
   e. Esophageal complications, including esophagitis, ulcerations, strictures, and tracheoesophageal fistulas.
   f. Leaking around the insertion site, abdominal wall abscess, or erosion at the insertion site, including nasal areas.
   g. Clogged tube due to plugging by formula, pill fragments, or precipitation of medications incompatible with the formula.
2. Enteral feeds will be resumed by physician order, which may include radiologic evaluation or reassessment of the goals of enteral feeding
3. Notify physician and registered dietitian:
   a. If resident has unplanned significant weight gain or loss or if a reassessment of goals of nutritional support is indicated. Refer to NPP G 7.0 Obtaining, Recording and Evaluating Residents Weights.
   ~~b.~~ If the Intake and Output monitoring indicate the resident is consistently receiving less than the enteral nutrition goal volume.

~~**H.** Care of Enteral Tube (Refer to Appendix 2)~~

b.

~~1.~~ ~~**NGT**~~

~~a. Examine nasogastric tube daily for damage. Prior to accessing the tube, examine the feeding tube, stopcock and the infusion plug for any splits or cracks that could produce leakage, and if found, notify the physician promptly.~~

~~b. Nasogastric tube is to be changed every 4 weeks, as indicated or as ordered, and alternate nostrils if possible.~~

~~c. Inspect skin for signs of skin breakdown. Weekly or as needed, relocate the tube in the nostril so the tube is not in contact with the same site to prevent skin breakdown~~

~~d. Change tape over the nose bridge as needed. Ensure tube is effectively secured externally (refer to Procedure A2 Insertion of NGT).~~

~~e. Provide regular oral care including inspection of the back of the mouth to check for coiling of tube.~~

~~2. **G-Tube and J-Tube**~~

~~a. Inspect tube and stopcock daily for damage and skin daily for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage. Notify physician for any signs of skin breakdown.~~

~~b. New tube (insertion tract less than 6 weeks old): Daily stoma care or per order.~~

~~i. Explain procedure to resident.~~

~~ii. Wash hands and wear gloves prior to providing site care.~~

~~iii. For the first 7 to 10 days after initial insertion, stabilize tube with one hand while cleaning skin to remove crusts.~~

~~iv. Clean the site with clean swabs moistened with normal saline.~~
~~v. Dry skin thoroughly.~~
~~vi. A moisture barrier cream skin protectant may be used to protect skin from drainage.~~
~~vii. If a dry 4 x 4 drainage/split gauze dressing is applied over the external bumper, change it as soon as the dressing becomes wet.~~
~~viii. Secure the tube externally to prevent accidental dislodgement, migration or excessive traction.~~

~~c. Established tube (insertion tract at 6 weeks or older): Daily stoma site care for a healed site.~~
~~i. Explain procedure to resident.~~
~~ii. Wash hands and wear gloves prior to providing site care.~~
~~iii. Remove old dressing if there is one and inspect skin around the stoma for signs of irritation, drainage, or leakage. Report abnormal findings to physician as needed.~~
~~iv. Clean the skin gently. Start at the site and move outward, using moistened cloth or gauze. Clean under external bumper with cotton tipped applicator. Rinse and dry skin thoroughly.~~
~~v. Avoid using a dressing if possible, but if needed, apply and tape a 4x4 drainage/split gauze over the external bumper which must be kept close to the skin.~~
~~d. Trace tubes back to their origins to prevent misconnections and ensure lines are secure at the beginning of each shift and during reconnections.~~
~~e. Prior to accessing the tube, examine the feeding tube, stopcock and the infusion plug for any splits or cracks that could produce leakage, and if found, notify the physician promptly.~~
~~f. G-tubes typically have external bumpers to prevent inward migration. External bumper must fit appropriately to prevent both internal and external pressure (such as buried bumper) and permit cleaning under the bolster. A slim layer of light breathable gauze can be inserted over the disc, if indicated. An external disc that is too loose, permitting internal and external movement of the tube (positioning), may let gastric contents leak through the gastrostomy opening, which then may lead to skin excoriation and other complications.~~
~~g. Use a stabilization device (ex: Statlock or M Fixx) to secure/anchor the tube to prevent excessive tension to the exterior portion of the tube.~~
~~h. **Fit of the gastrostomy tube should allow for easy rotation of the tube and permit cleaning under the bumper. Jejunostomy and gastrojejunal tubes should not be rotated.**~~

~~I.~~G. Documentation

Goals of Medical Enteral Feeding

1. Nutritional and Quality of Life goals are documented in the Resident Care Conference (RCC) note.
2. Goals of enteral feeding may be documented in Advance Care Planning by the physician.

EHR Documentation by the Licensed Nurse

1. Flowsheet or Lines, Drain and Airways (LDA) and Flowsheets
   a. Admission and Tube Insertions:
      i. If the tube was inserted at a DPH facility, continue the LDA.
      ii. Document the tube properties and assessment under LDA.
      ~~iii. Document tube assessment under LDA.~~
      ~~iv.~~iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered
   b. Removal and Replacement:
      i. Document the removal of the original tube (permanent removal or planned replacement) under the LDA, including the remove date, removal time, removal reason.
      ii. Document the replacement by initiating a new LDA.

iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered.

c. Documentation:

~~i.~~ Every shift and as needed: document the tube assessment under LDA.

i.

ii. Intake and Flush volume: Prior to the end of EACH shift, the Licensed Nurse:

i.i Checks the feeding pump anand ~~dd notes the volumes for "FED" and "FLUSH".~~

~~i.ii~~ Documents the volumes for "FED" and "FLUSH" at the end of the shift.

i.iii Clears the pump of the volumes for "FED" and "FLUSH".

i.iv Documents the volume of fluid used for flushes and medications during the shift.

~~ii. Daily and as needed: tube feeding administration set changed~~

iii. As needed:

i.i Any other problems with enteral tube management (e.g., frequent obstruction, etc.)

i.ii ~~-~~Resident's tolerance or intolerance of feeding.

2. Education: Document any resident or family teaching provided and evaluation of learning
3. Care Plan:
   a. Care plan the clinical indication, as noted by the physician, which necessitates enteral tube placement and enteral nutrition.
   b. Include any related or potential problems, or resident needs.
   Examples of some possible adverse effects of using a feeding tube may include: diminishing socialization, and not having the opportunity to experience the taste, texture, and chewing of foods.

Non-EHR Documentation by the Licensed Nurse

Document daily enteral feeding supplies used on the Enteral Nutrition Charge Form. Refer to LHHPP 50-04 (Enteral Nutrition Charge Procedure).

ATTACHMENTS/APPENDICES:

Appendix 1: Preparation for Enteral Nutritional Support – Closed and Open System
Appendix 2: Enteral Pump Hang Tag provided by the manufacturer
Appendix 3: Enteral Nutrition Chart

REFERENCES:

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CROSS REFERENCES:

Hospitalwide Policy and Procedure
- 26-03 Enteral Tube Nutrition
- 50-04 Enteral Nutrition Charge Procedure

Nursing Policy and Procedure
- G 3.0 Intake and Output
- G 4.0 Measuring the Resident's Height and Weight
- J 1.0 Medication Administration and Appendices

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Reviewed: 2022/11/08
Approved: 2022/11/08

APPENDIX 1 - Enteral Nutritional Support - Closed and Open Systems

~~**A. Definition**~~

~~**Closed System** is used for enteral nutritional support when products are available in pre-filled closed containers. Closed system is preferred to be used whenever possible to reduce opportunity for contamination. Closed enteral containers must be labeled with the resident name, bed number, rate, date and time container is hung. The labeled date and time on the container also applies to the tubing. Closed enteral containers will only be spiked once with new, sterile tubing set.~~

~~**Open System** is used for enteral nutritional support when products are not available in pre-filled closed containers. Open systems require nutritional products to be transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing. Open enteral bags must be labeled with the resident's name, bed number, formula, rate, date and time the bag is hung. The date and time on the bag also applies to the tubing. Open enteral bags used for formula must be discarded after each use. Open enteral bags used solely for water must be discarded within 24 hours after they are initially hung.~~

~~B.~~A. Administration of Formula Feeding

1. **CLOSED SYSTEM**

   a. Equipment~~s~~

      Gather all equipment~~s~~ needed from neighborhood supply room or Central Supply Room:

      i. infusion pump with tubing set
      ii. 60 ml catheter tip feeding syringe

      Obtain the prescribed enteral formula from the Galley or Dietary Department~~: Prescribed enteral formula~~.

   ~~b.~~ Preparation of Nutritional Products
   b.

      i. Wash hands with soap and water or use hand sanitizing product.
      ii. Follow physician orders and nutritional product instructions on container.
      iii. Check expiration date of enteral formula.
      iv. Enteral formula ~~eeding~~ should be at room temperature.
      v. Shake container for 5-10 seconds prior to spiking to mix formula evenly.
      vi. Remove ~~sticker tab from top of~~ container lid. Do not remove the cap from the container.
      vii. Label container with ~~date,~~ resident name, bed number, rate, staff initials, date and time container is hung.
      viii. Spike enteral nutrition container using the open port in the cap, not the air vent; and fill water bag with room temperature tap water prior to setting the pump.
      ix. Program the pump per manufacturer instructions. Refer to Appendix 2. ~~Follow instruction enteral pump hang tag provided by the manufacturer (Refer to Appendix 2).~~ Use **"continuous mode"** for both continuous and intermittent feeding.
      x. Confirm proper positioning of the resident and correct placement of enteral feeding tube per nursing and hospital policy (Refer to NPP E 5.0 and LHH File 26-03).
      ~~xi. Closed enteral containers and attached tubing are discarded when the container is empty, OR within 48 hours after closed enteral container is hung.~~

~~xii. Tubing sets are never to be re-used and will be discarded along with the used container.~~
~~xiii. Syringes are to be changed every twenty-four (24) hours.~~

2. **OPEN SYSTEM**

a. Equipment~~s~~

Gather all equipment~~s~~ needed from neighborhood supply room or Central Supply Room:

i. infusion pump with open system tubing set or gravity feeding bag for bolus feeding
ii. 60 ml catheter tip feeding syringe

Obtain the prescribed enteral formula from the Galley or Dietary Department~~: Prescribed enteral formula~~.

~~b.~~ Preparation of Nutritional Products
b.

i. Wash hands with soap and water or use hand sanitizing product.
ii. Follow physician orders and nutritional product instructions on container.
iii. Wipe top of unopened container with alcohol wipe before opening. Avoid touching any part of the formula container or the administration set that will come in contact with the formula.
~~iv.~~ Make sure formula is at room temperature by any of these means:
iv.

1. Store unopened formula at room temperature.
2. Place refrigerated formula cans in a pan of warm water.
3. Add warm water, as ordered, to the formula.

~~v.~~ Partial cans of formula:
v.

1. Cover, date and initial container.
2. Place in household refrigerator to use for next formula preparation.
~~3.~~ Discard unused formula after 48 hours.
3.

vi. Enteral bags are labeled with resident's name, bed number, formula, rate, staff initials, date and time bag is hung.
vii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.
~~vii.~~viii. Program the pump per manufacturer instructions. Refer to Appendix 2. ~~Follow instruction enteral pump bag tag provided by the manufacturer (Refer to Appendix 2).~~ Use **"continuous mode"** for both continuous and intermittent feeding
~~viii.~~ix. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.
~~ix. Confirm proper positioning of the resident and correct placement of enteral feeding tube per nursing and hospital policy (Refer to NPP E 5.0 and LHH File 26-03).~~
~~x. Do not re-use bags. When the tube feeding is completed, discard tubing and use a clean one. Syringes are changed every 24 hours.~~

~~c.~~ Administration of high protein powder supplement with water using open enteral system:
c.

i. Put 60-120 ml of water in the enteral feeding bag.
~~ii.~~ Add the amount of protein powder ordered.

~~2~~

ii.

iii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.

~~iii.~~iv. Program the pump per manufacturer instructions. Refer to Appendix 2.~~Follow instruction enteral pump bag tag provided by the manufacturer (Refer to Appendix 2).~~ Use **"continuous mode"** for both continuous and intermittent feeding.

~~iv.~~v. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.

~~C.~~B. Administration of Free Water

~~1.~~ Using Syringe

1.

a. Use 60 ml syringe.
b. Attach the syringe to the tube port.
c. Pour water from the resident's water pitcher into the feeding syringe.
d. Administer water by gravity through enteral tubes unless the gastrostomy is short, such as the Bower REG. These tubes do not have adequate length for fluids to flow by gravity from a syringe. In this case, use a 60 ml catheter-tip syringe and, with the plunger, slowly and gently push fluids through the tube into the stomach.

~~2.~~ Using an Enteral Bag

2.

a. See above procedures for open & closed systems.

3. In open systems, free water may be added to directly to the feeding bag, unless contraindicated.

~~D.~~C. Charging Slips for Enteral Formula

1. Refer to LHHPP File 50-04 Enteral Feeding Charges.

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Approved: 05/28/2013

APPENDIX 2 – Enteral Pump Hang Tag

Enteral Feeding Pump (Kangaroo ePump™)

A. Flushing Mode Operation

1. General Instructions

a. Fill or spike feeding container and water bag prior to setting up pump.
b. Turn pump on – Press **POWER** button in the lower right-hand corner.
c. In order to achieve proper accuracy, the bottom of the feeding set bag must be 18 inches above the feeding pump.
d. Select ► **"Keep Setting"** or ► **"Clear Settings"** (for day to day use with the same feeding regimen the ► **"Keep Setting"** option should be selected).
e. Load the set. Do not overstretch tubing.

2. Priming the Pump

a. Press ► **"Pump Prime"** to access the pump priming options.
b. Press ► **"Auto Prime"** to automatically prime the pump set. The pump will quickly prime both feed and flush lines starting with the flush line. The formula will stop before reaching the end of the feeding line.
c. Press ► **"Hold to Prime"** menu selections to manually top off the line.
d. Press ► **"Done"**.

3. Setting the Feed Rate and Flush Volume

Feed Rate

a. Select ► **"Adjust Feed"** then ► **"Feed Rate"** use the buttons on the left to program the pump from 1 to 400 in increments of 1 ml. Select ► **"Enter"** when desired rate is set. Note the **Volume to be Delivered "VTBD"** – is an optional Feature. Use only the "VTDB" option if you want the pump to stop and alarm once a set amount of formula is delivered.

Flush Volume

b. Select ► **"Adjust Flush"** then ► **"Flush Volume"** to set the volume of water per flush cycle to be administered from 10 to 500 in increments of 1 ml. Select ► **"Enter"** when desired rate is set.
c. Select ► **"Flush Interval"** to define the time interval between the start of each flushing cycle from 1 to 24 hours in increment of 1 hour. Select ► **"Enter"**, select ► **"Done"**.
d. Select ► **"Run"**. You will notice a small drop • scrolling down the screen when running.

~~4. Re-Priming the Pump After the Feed Bag Empties~~

~~a. A pump set bag that has been emptied will trigger the **Feed Error** screen. In this condition the pump set bag can be refilled to continue the feeding, but only after the pump set has been re-primed.~~
~~b. Disconnect the feeding line from the patient.~~
~~c. Refill the bag.~~
~~d. Press ► **"Continue"** to begin the pump running.~~
~~e. Press ► **"Hold"**, then press ► **"Adjust Settings"**, then press ► **"Pump Prime".**~~
~~f. Press ► **"Hold To Prime Flush"** until water has reached the valve in the pump.~~

~~g. Press ► **"Hold To Prime Feed"** until formula reaches the stepped connector at the end of the set.~~
~~h. Press ► **"Done"**, then select ► **"Run"**.~~

~~5.~~4. **Changing Rate or To Clear Volume**

a. Select ► **"Hold"**.
b. Select ► **"Clear Vol"**.
c. Select ►**"Adjust Settings"** to adjust all settings.
d. Select ► **"Run"** to return to normal operations.

~~**Pump sets should not be reused after 24 hours of initial usage.**~~

B. Trouble Shooting Guide

SYMPTOMS	PROBABLE CAUSE	CORRECTIONS
Hold Error	Pumping in **HOLDING** mode for more than 10 minutes.	Press ► **Continue** to return to **HOLDING** screen, or press and hold the Power button to turn off. Several options are available from the **HOLDING** screen, such as **RUN** or **ADJUST SETTINGS**.
Flow Error	Occlusion in pump-patient line. (downstream occlusion)	Check for and correct occlusion in the line between pump and patient. Replace Pump Set if error cannot be resolved.
Feed Error	Empty bag or occlusion in bag-pump line. (upstream occlusion)	Check for empty bag, if empty discard and use a new set-up ~~and refill~~, or check and connect the occlusion in the line between the pump and feed bag. Replace Pump Set if error cannot be resolved.

Flush Error	Empty bag or occlusion in flush line.	Check for empty bag, if empty discard and use a new set-up ~~and refill~~, or check and connect the occlusion in the line between the pump and flush bag. Replace Pump Set if error cannot be resolved
Flow Error Use > 24 Hrs	Pump Set in use beyond recommended length of time.	Informational warning message blinks on the upper left of screen. It is recommended that the Pump Set be replaced.

Pump Set Dislodged	Pump Set not properly loaded to pump.	Check black ring retainer (MISTIC) and valve; reload Pump Set and restart pump to continue. Replace Pump Set if error cannot be resolved.
Battery Low	Battery charge too low.	Immediately plug pump in A/C outlet to recharge battery and to provide power for pump.
Rotor Error	Pump Set tubing not properly loaded on rotor, or some other unusual rotor operating condition.	Check that the tubing is loaded on the rotor and that is not damaged, torn, etc. Reload tubing or replace Pump Set.
System Error	General error caused by many factors. See Manual for error list.	Power down pump and attempt restart to clear error. Call customer service (1-800-962-9888 or 508-261-8000) with screen code if error cannot be resolved.

C. Battery Operation

Unplugging the pump from the AC line will automatically put the pump on battery power. To charge the battery, plug the pump into an AC wall outlet. Pump will automatically begin charging.

REFERENCE:

2009 COVIDIEN Kangaroo ePump™ Reference Guide

CROSS REFERENCES:

LHHPP File: 26-03 Enteral Tube Nutrition
LHHPP File: 50-04 Enteral Feeding Charges

Nursing P&P E 5.0 Enteral Tube Feeding Management
Nursing P&P G 4.0 Measuring the Height and Weight
Nursing P&P G 3.0 Intake and Output (I&O)
Nursing P&P J 1.0 Medication Administration and Appendices

New: 05/28/2013

Approved: 05/28/2013

APPENDIX 3 – Enteral Nutritional Chart

	Nasogastric Tube (NGT)	Gastrostomy Tube (GT)	Jejunostomy Tube (JT)
Can be inserted or replaced by ~~Registered Nurse (RN)?~~Nurse	Yes (LVN & RN)	Yes (RN), if the GT is simple, balloon type and the GT tract is more than 6 weeks old	No
Can be removed by Nurse~~RN~~?	Yes (LVN & RN)	Yes (RN), if the tube is being replaced	No
Should the tube be rotated prior to replacement?	No	Yes – only simple balloon GT	No
Frequency of routine tube change by RN	64 weeks, alternate taping side within the same nostril weekly	3 months	N/A
Gastric residual appearance	• Fasting gastric fluid is clear and colorless, grassy green, pale yellow or brown. Continuous tube feeding aspirates have • curdles enteral formula appearance.	• Fasting gastric fluid is clear and colorless, grassy green, pale yellow or brown. Continuous tube feeding aspirates have • curdles enteral formula appearance.	Aspirates may be minimal to none, and are yellow or brown colored.
Placement check	Tube length, gastric residual appearance, symptoms of dislodgement, examine oropharynx	Tube length, gastric residual appearance, symptoms of dislodgement	Tube length, gastric residual appearance, symptoms of dislodgement

New: 2019/05/14

Reviewed: 2019/05/14

Approved: 2019/05/14

MEDICATION ADMINISTRATION

POLICY:

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

    a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.
    b. The LVN may administer medications per LVN scope of practice, except for IV medications.
    c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.
        - Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications, require a physician's order which includes:
    a. Medication name/agent
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.
        - If indication for use is not on order, consult with ordering physician.
3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:
    a. Right resident
    b. Right drug
    c. Right dose
    d. Right time
    e. Right route
    f. Right documentation

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

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

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

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

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

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

~~11. Narcotic (opioid) medication administration will have a two LN independent check of administration and each LN will document in EHR.~~

~~12.~~11. IV medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

~~13.~~12. Medication delivered via transdermal route must have date, time, and LN's initials. Before application of new patch, old transdermal patch must be removed.

~~14.~~13. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

~~15.~~14. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

~~16.~~15. Medications may not be added to any food or liquid for the purpose of disguising the medication, unless informed consent has been granted by the resident or the surrogate decision maker.

~~17.~~16. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container, including crushed, dissolved, or disguised medications. Non-hazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

~~18.~~17. Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted with co-signer/other LN at the time of retrieval from Omnicell.

a. 2nd LN shall witness when the medication is still in the sealed packaging, and the actual wasting of the partial dose.
b. Partial doses should not be placed in medication cart for administration at later time.

~~19.~~18. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

~~20.~~19. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

~~21.~~20. Oral medications that are safe to be crushed can be crushed at the discretion of the LN.

~~22.~~21. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications, and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

~~23.~~22. A provider order must be obtained for medications to be mixed with pudding.

~~24.~~23. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

~~25.~~24. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

~~26.~~25. Topical creams and ointments that are ordered "until healed" can be discontinued by the LN via an order in the EHR, and ordered "per protocol, co-sign required".

~~27.~~26. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

~~28.~~27. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone, rescue inhalers, and other documented, approved rescue medications if ordered. If an approved medication is to be stored at the bedside, the resident must be assessed for their ability to ensure that the medication is stored safely.

~~29.~~28. Residents who request to self-administer medications must be assessed by Resident Care Team (RCT), and determined to be able to safely self-administer medications.

~~30.~~29. Herbal supplements are not medications. Please see Herbal Supplement Policy for guidance around ordering, use, and storage of herbal supplements.

~~31.~~30. All medications for self-administration will be stored securely by nursing, with the exception of nasal naloxone, rescue inhalers, or other documented approved rescue medications.

RELEVANT DATA & DEFINITIONS:

BCMA: Bar Code Medication Administration
eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record
EHR: Electronic Health Record
WOW: Workstation on Wheels

CRITICAL POINTS:

A. SIX RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT RESIDENT
    - Two forms of identification are mandatory.
        - Verify identity of resident using any of the following two methods:
            - Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)
            - Resident is able to state his/her first and last name (Ask for first and last name without prompting)
            - Resident Medication Profile Photograph matches the resident image in the EHR.
            - Resident is able to state date of birth (Ask without prompting.)
            - In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.
            - Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

2. RIGHT DRUG
    - Review eMAR for drug/medication ordered
    - Review resident allergies to medications or any other contraindication
    - Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

- Checks or verifies information about medication using one or more of the following references, when needed:
  - Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
- Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

3. RIGHT DOSE
   - Review eMAR for dose of drug/medication ordered
   - Check medication label and confirm accuracy of dose with eMAR

4. RIGHT TIME
   - Review eMAR for medication administration time
     - Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.
     - All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
     - See Appendix I for routine medication times and abbreviations.
     - Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.

5. RIGHT ROUTE
   - Review routes of administration
     - Aerosol/Nebulizer: Refer to NPP J 1.3
     - Enteral Tube Drug Administration: Refer to NPP E 5.0
     - Eye/Ear/Nose Instillations: Refer to J 1.4
   - IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

6. RIGHT DOCUMENTATION
   - Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.
   - If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.
   - If product/medication is not scanned, document the reason in override section.

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

C. TWO LN INDEPENDENT CHECK OF MEDICATIONS:

1. Two LN independent check of medication is the process by which 2 LNs perform an independent review of the medication to be administered, without prompting or cueing for other LN prior to medication being administered: Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time. Each LN will complete their own documentation in EHR.

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

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

2. Do not crush hazardous, enteric, sustained release or medications labeled “do not crush.”

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

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

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

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

7. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:
    a. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.
    b. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)
    c. If using pudding as the food medium to administer medications, a physician order is required for the pudding.
    d. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

E. HAZARDOUS MEDICATIONS

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

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

F. PHYSICIAN ORDER

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

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

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

PURPOSE:

Medications will be competently and safely administered

PROCEDURE:

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

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.
    a. Pull those resident's cassettes from medication cart and place on top of WOW, or bring med cart inside med room if space permits.
        i. Ensure each cassette is labeled with the correct resident name.
        ii. Do not overcrowd the WOW with too many cassettes.
    b. Bring WOW with the resident(s) medication cassette(s) into the medication room.
        i. If using medication cart with computer screen attached, bring the entire cart into the medication room.
    c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.
    d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.
        i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.
    e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.
    f. Repeat this for each resident that need medication(s) removed if needed.
    g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.
        i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette, and immediately followed by placing cassettes in medication cart.

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

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

5. Scan the arm band of resident to correctly identify resident and open their MAR.
    a. If the resident is wearing their arm band, this will serve as ~~is~~ one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.
    b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.
    c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

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

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

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

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

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

    a. Never leave medications at the bedside/chairside.

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

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

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

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

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

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

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

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

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

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

    a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).
    b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.
    c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

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

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

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

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

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

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

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. Narcotic medication administration may happen after performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:
    i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.
    ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.
    iii. .
2. Administration of buprenorphine-naloxone.
    a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed..
    b. Buprenorphine administration is as follows:
        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.
            1. 5-10 minutes for sublingual tablet
            2. 3-8 minutes for film
        ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.
        iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.
    c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).
        i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor resident

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

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

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

B. Administration

1. Refer to Appendix 4, follow Manufacturer’s Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

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

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

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

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

    a. Use with nebulizer face mask, which has medication cup and lid.
    b. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.
    c. Air source
        i. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.
        ii. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
        iii. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO_2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.
    d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

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

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

2. Assess the resident's response to treatment.

SPECIAL CONSIDERATIONS:

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

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

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

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

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

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

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

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

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

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

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

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

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to dilute the dose thoroughly, immediately before administration.
2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”
3. Any rolling motion used is acceptable as long as the suspension appears milky and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.
2. Every cardiovascular drug requires vital sign monitoring as outlined below:
    a. Frequency of monitoring:
        i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.
        ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.
    b. Default parameters:
        i. Hold medication for SBP < 105 and/or hold for HR < 55.
        ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.
    c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.
    d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.
    e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

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

SPECIAL MONITORING REQUIREMENTS

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

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

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

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

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

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

SHIFT-TOSHIFT LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:
    a. Any new medications started, indication and monitoring required.
    b. Any suspected Adverse Drug Reactions (ADRs).
    c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.
    d. Time or food sensitive medications to be given on incoming shift.
    e. PRNs given at end of shift requiring evaluation of effect.
    f. Refusal of medication.

FENTANYL TRANSDERMAL (PATCH) APPLICATION AND DISPOSAL (Refer to Pharmacy P&P 02.02.02)

1. Application
    a. Don gloves during any time you will be touching patch.
    b. If resident currently has a patch on, remove the old patch before applying a new patch.
    c. Select appropriate site for patch, on flat area, such as chest, back, flank or upper arm. Apply patch to non- irritated, non-irradiated skin.
    d. Clip hair if needed (Do Not shave) prior to applying patch. Avoid use of oils, alcohol, or soaps to surface area as they may affect patch adhesion or drug absorption. Allow skin to dry completely before applying patch.
    e. Peel liner from the back of the patch and press patch firmly to skin using the palm of the hand for at least 30 seconds to obtain seal.
    f. Date and initial patch after application.

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

3. Verification of patch placement and monitoring
    a. Inspect site of application every shift to verify that the patch remains in place.
    b. Document verification in the eMAR.
    c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.
    d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.
    e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.
    f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.

4. Disposal
    a. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.
    b. Document disposal on the eMAR.
    c. A waste/witness co-signature is required for a used patch.

SELF-ADMINISTRATION

~~AND BEDSIDE MEDICATION~~

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

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:
    i. The medications appropriate and safe for self-administration;
    ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;
    iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;
    iv. The resident's capability to follow directions and tell time to know when medications need to be taken;
    v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
    vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.
    vii. The resident's ability to ensure that medication is stored safely and securely. Appropriate notation of these determinations must be documented in the resident's medical record and care plan

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer ~~a~~ medication this will be communicated to the physician and to the resident ~~a~~.
c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.
d. Orders will be entered in the EHR for medications and herbal supplements. ~~A nursing communication order listing non-formulary herbal supplements will be entered in the EHR.~~
e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering. The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. ~~(Unless ordered for bedside by physician as indicated in the care plan.)~~
f. The LN will observe self-~~medication~~ administration preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated.
g. If the nurse notices the resident is about to make an error, ~~he/she~~the nurse will intervene to

stop the preparation. ~~He/she~~The nurse will also discuss and clarify with the resident the accurate manner of self-~~administering medications~~administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer ~~medications safely~~, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

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

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

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

~~Residents who self-administer herbal supplements will maintain their supply and will take responsibility for self-administration and safe storage.~~

~~Resident will be instructed to notify physician of changes, additions or discontinuation of herbal supplements.~~

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

The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications~~The resident must be assessed by the Resident Care Team (RCT), and determined to be able to safely self-administer medications and/or ordered and approved herbal supplements. See Herbal Supplements: Formulary and Non-Formulary policy.~~

~~**1. Self-Administration**~~

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

~~b. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note.~~

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

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

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

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

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

~~h. The LN observing the resident taking the appropriate prescribed medications and/or ordered herbal supplements, and the LN will document in MAR as given and will note "self-administered".~~

~~i. Education and training skills will be documented and care planned in the EHR.~~

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

a. Prior to providing nasal naloxone, a rescue inhaler or other approved rescue medication at the bedside, the RCT shall determine that the resident can safely self-administer the medication and an appropriate individualized plan of care shall be written.

b. Medication(s) for bedside storage must be safely stored by resident. The Pharmacy will label all bedside medications in appropriate lay-language.

c. The medication used will be recorded in the resident's health record, based on observation or resident self reporting of the medication being administered.

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).
   a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Nonhazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.
      i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.
      ii. Empty medication cups go in the garbage.
      iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.
      iv. The empty spoon can go in the garbage.
      v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.
      vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.
      vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.
      viii. Empty packets of powered medications can be thrown in the garbage.

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

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

   a. The need for partial wasting shall be identified prior to leaving the medication room.
   b. A 2nd LN shall be present to initiate controlled substance waste.
   c. The 2nd LN shall witness both when the medication is still in the sealed packaging and the wasting of the partial does.
   d. Both LNs shall document the waste in Omnicell.

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

   a. A 2nd LN will provide the co-sign in Epic will also witness the waste of the controlled substance in the Omnicell.
   b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.
      i. This may be done via looking up the IC medication tag through Lexicomp.

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

the resident.
d. Both LNs shall document waste in Omnicell and the MAR.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the the EHR for each out-on-pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.
   a. The nurse will have the order filled at the hospital Pharmacy.
   b. The pharmacist will dispense the medications in properly labeled child-proof containers.
   c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply, and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.
   a. Controlled substances **may not** be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.
   b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.
   c. The physician will counsel the resident on proper use of his/her medications.

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

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:
   a. Will be given to family or guardian to take home.
   b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.
   c. Pharmacy manages the medications and may dispose of as necessary.
   d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.
   e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

   Personal medications will not be obtained, stored or used by residents. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, notify pharmacy for replacement.

EXCESS MEDICATIONS

1. If resident is refusing medications and there are an excess of medications, notify the Pharmacy.

ATTACHMENTS:

Appendix I Specific Medication Administration Times

Appendix II Use of Identification Cards for Resident Identification for Bar Code Medication Administration

Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

REFERENCES:

Lexicomp Online website: http://www.crlonline.com/crlsql/servlet/crlonline

Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. *Institute for Safe Medication Practices*. Retrieved from http://www.ismp.org/tools/donotcrush.pdf or https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053

AeroChamber Plus® Flow-Vu® Cleaning Instructions

DeWit, Susan, Fundamental Concepts and Skills for Nursing, 3rd edition, 2009

EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)

Lippincott, Williams, & Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd ed, 2007

Nettina, Sandra, Lippincott Manual of Nursing Practice, 8th edition, 2005

CROSS REFERENCES:

LHHPP File: 25-01 High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibilities
LHHPP File: 25-13 Herbal Supplements: Formulary and Non-Formulary
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual
LHHPP File: 73-11 Medical Waste Management Program

LHH Pharmacy P&P 01.02.02 Stop Orders
LHH Pharmacy P&P 02.01.02 Disposition of Medications
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances
LHH Pharmacy P&P 02.02.00b Distribution of Medications and Medication Order Processing

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds

Nursing P&P J 1.3 Aerosol/Nebulizer Medications.
Nursing P&P I 5.0 Oxygen Administration
Nursing P&P J 7.0 Central Venous Access Device Management

Revised: 2000/10, 2006/01, 2008/01, 2010/10, 2011/03/15, 2013/09/24, 2017/01/05, 2017/11/04, 2018/07/10, 2019/03/12, 2019/07/09, 2019/09/10, 2020/01/14; 2020/03/17, 2021/02/24, 2021/09/14; 2022/05/10, 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

Deletion Nursing Policies and Procedures

APPENDIX I

Obtaining Nursing Documentation Forms, Medical Records, and Chart Order

1. Obtain blank chart forms from neighborhood supply or commissary.

2. Call HIS one day in advance for chart requests.

3. New and closed medical records are delivered from 9:00 A.M. to 4:00 P.M., Monday through Friday, except holidays.

4. Requests for same day deliveries of closed medical records are accepted when residents are readmitted, or when needed for a unit or clinic physician's review. HIS requests notification as early as possible in the day, preferably before 8:00 A.M. Be sure to specify when a chart is requested for readmission.

5. All charts obtained from HIS are to be returned within 72 hours.

6. All residents discharged within house, home or to outside facilities must have their records forwarded to HIS the day of discharge.

7. Nursing forms chart order:

Progress Notes Section 1. Integrated Progress Notes 2. RCT Note Sticker 3. Focused Progress Notes 4. Nursing Weekly/Summary
Assessment Section 1. Nursing Admission Assessments 2. Resident Comprehensive Pain Assessment 3. Nursing Assessment for Behavioral Risk 4. Pressure Ulcer Risk Initial Post-Admission 5. Wound Assessment Records 6. On-going Pressure Ulcer Risk 7. Continence Assessment 8. Post-Fall Assessment 9. Self-Administration of Medication: RCT Assessment 10. Safe Smoking Assessment
MDS Section
1. MDS Admission Assessment 2. MDS Face Sheet Information 3. MDS Discharge Tracking Form 4. MDS Correction Request Form 5. RCT Meeting Note
Graphic Section 1. Weight Record 2. Diabetic Record 3. Neurological Assessment Record 4. Graphic Chart 5. Pain Intensity Graphic Record 6. Behavioral Summary Sheets

ADL Section 1. DNCR
Medication/Treatment Section 1. Medication Administration Record 2. I.V. Flow Sheet 3. CAPD Flow Sheet 4. Treatment Administration Record

8.

PROGRESS NOTES SECTION
1. INTEGRATED PROGRESS NOTES
2. IDT NOTE STICKER
3. FOCUSED PROGRESS NOTES
4. NURSING WEEKLY/MONTHLY SUMMARY
ASSESSMENT SECTION
1. NURSING ADMISSION ASSESSMENTS
2. RESIDENT COMPREHENSIVE PAIN ASSESSMENT
3. NURSING ASSESSMENT FOR BEHAVIOR RISK
4. PRESSURE ULCER RISK INITIAL POST-ASSESSMENT
5. WOUND ASSESSMENT RECORD
6. ONGOING PRESSURE ULCER RISK
7. CONTINENCE ASSESSMENT
8. POST FALL ASSESSMENT
9. SELF-ADMINISTRATION OF MEDICATION: IDT ASSESSMENT
10. SAFE SMOKING ASSESSMENT
MDS SECTION
1. MDS ADMISSION ASSESSMENT
2. MDS FACE SHEET INFORMATION
3. MDS DISCHARGE TRACKING FORM
4. MDS CORRECTION REQUEST FORM
5. IDT MEETING NOTE
GRAPHICS SECTION
1. WEIGHT RECORD
2. DIABETIC RECORD
3. NEUROLOGICAL ASSESSMENT RECORD
4. GRAPHIC CHART
5. PAIN INTENSITY GRAPHIC RECORD
6. BEHAVIORAL SUMMARY SHEETS
ADL SECTION
1. DAILY NURSING CARE RECORD
MEDICATION/TREATMENT SECTION
1. MEDICATION RECORD
2. IV FLOW SHEET
3. CAPD FLOW SHEET
4. TREATMENT RECORD

TOTAL PARENTERAL NUTRITION

POLICIES:

1. A Registered Nurse (RN), who is trained and competent, may administer and maintain Total Parenteral Nutrition (TPN) infusions upon physician order utilizing the EHR Parenteral Nutrition Order Set.

2. TPN infusions will not hang longer than 24 hours and the rate is regulated by a pump.

3. Total Parenteral Nutrition (TPN) solution including greater than 10% dextrose cannot be abruptly discontinued.

4. Laguna Honda only provides TPN and administration is limited to neighborhood Pavilion Mezzanine and South 2.

PURPOSE:

To provide safe delivery and maintenance of Total Parenteral Nutrition.

BACKGROUND INFORMATION:

Parenteral Nutrition (PN) is the intravenous (IV) administration of nutrients in residents/patients without a functional or accessible gastrointestinal (GI) tract and provides protein in the form of amino acids, carbohydrates as dextrose, fats, vitamins, minerals, and trace elements (Weinstein, M.E. & Hagle, 2014). The two types of PN are; Total Parenteral Nutrition (TPN), Partial or Peripheral Parenteral Nutrition (PPN).

TPN is a formula that contains complete nutrition, and due to the high osmolality and dextrose content it must be given via CVAD (i.e., PICC, implanted portacath or other subclavian catheter). The term “3 in 1 PN” refers to the combination of a 24-hour supply of dextrose, amino acids, fat emulsion (lipids), electrolytes, trace elements and vitamins in one TPN bag.

Complications related to PN can include: catheter-related infection, non-catheter related infection, hyperglycemia, hypoglycemia, electrolyte imbalance, elevated liver function tests (i.e., AST, ALT, Alkaline Phaosphatase), non-ketotic hyperosmolar state, air embolism, fat embolism, subclavian vein thrombosis, peripheral vein thrombosis.

PROCEDURES:

A. Equipment:	**Obtained From:**
24 hour TPN solution (may include lipids if ordered)	LHH Pharmacy
Tubing with in-line filter (if solution does not contain lipids)	LHH Pharmacy
Lipid tubing, 1.2 micron in-line filter (if lipids included)	LHH Pharmacy
Infusion pump	CSR
Luerlock connections	CSR
Mask	Nursing Unit
Gloves	Nursing Unit

B. Preparation:

1. Remove the TPN solution from the refrigerator 1 hour before use.

2. Explain procedure to resident/family and organize equipment.

3. Obtain baseline vital signs (blood pressure, temperature, heart rate, and respiratory rate) on initiation of TPN and repeat every 8 hours for 48 hours.

4. Obtain blood glucose per MD orders on Adult Parenteral Nutrition Order Form.

5. Inspect TPN solution for cloudiness or precipitate. Notify Pharmacy Services immediately if present and do not hang bag.

6. Two RNs will double check the TPN bag prior to administering, comparing the solution label with the physician's order for correct components, checking expiration date, and checking the bag number on the TPN bag regarding proper sequence of bags.

7. Pharmacy will number the TPN bags in sequence due to the prescription of the contents changing.

8. TPN Infusion Procedures

    a. Follow procedures/guidelines outlined in NPPs (J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Central Catheters (PICC) Management) to attach TPN tubing with in-line 0.22 micron filter to CVAD/PICC using aseptic technique. 1.2 micron filter is used when TPN is mixed with lipids.
    b. If multiple lumen catheter, remember to use DISTAL LUMEN for TPN only.
    c. Luerlock all tubing junctions to avoid accidental disconnection and air embolus.
    d. Change TPN bag and tubing every 24 hours and label with date and time.
    e. Label the port dedicated for TPN purposes only.
    f. Always use infusion pump to monitor rate of infusion as ordered.
    g. No other infusions, solutions, or medications shall be piggybacked into a Total Parenteral Nutrition line.

C. Monitoring:

1. Vital Signs: After the first 48 hours monitor daily for the next 5 days, then whenever clinically indicated. Notify MD for temperature T > 100.4 °F. See Preparation Section # 3.

2. Input and Output (I&O): Record I&O every shift.

3. Weights: Monitor and record weights weekly at a minimum, or more frequently per MD orders in the EHR Adult Parenteral Nutrition Order Set.

4. Glucose Monitoring: frequency of monitoring per MD orders n the EHR Adult Parenteral Nutrition Order Set.

5. Laboratory Monitoring: frequency of monitoring per MD orders n the EHR Adult Parenteral Nutrition Order Set.

6. Observe for, and instruct resident when appropriate, to report, signs and symptoms such as CVAD site pain, redness, swelling, feeling febrile, chills, shortness of breath, headache, change in mental status, thirst, increased urination, sweating, and etc. Notify MD as indicated.

7. Encourage and provide frequent mouth care each shift and PRN.

8. Encourage activity as tolerated.

D. Discontinuation of TPN

1. TPN must be weaned per MD order and cannot be discontinued abruptly.

2. Follow glucose monitoring orders per MD order during weaning process.

3. Teach resident/patient to report symptoms of hypoglycemia and monitor for signs of hypoglycemia.

4. Discuss with MD whether the need for intravenous fluids will be required after the discontinuation of TPN.

E. Documentation:

1. Electronic Health Record (EHR)
   a. Every shift for the first 7 days, and when clinically indicated, document the following:
      i. Resident's tolerance (e.g. elevated temperature, abnormal vital signs, nausea/vomiting, elevated blood glucose) and response to TPN
      ii. Physician notification if required
      iii. Resident/patient education if provided

2. Bar Code Administration Record
   a. Record the solution used, flow rate and administration times
   b. Double check with 2 RNs
   c. Change of bag and tubing

3. Electronic Health Record (EHR)
   a. At end of shift, chart the amount of TPN intake during the shift on the IV flow sheet and the PN solution balance remaining.
   b. Intake and Output
   c. CVAD/PICC site inspection daily
   d. CVAD/PICC dressing change (Refer to CVAD policy)
   e. Vital Signs
   f. Weight

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Weinstein, S.M. & Hagle, M.E. (2014). Plumer's principles and practice of infusion therapy, 9th edition. Chapter 16, Lippincott Williams & Wilkins, Philadelphia, Pennsylvania.

Lexicomp – Total Parenteral Nutrition

ASPEN – Guidelines for the use of -parenteral and enteral nutrition in adult and pediatric patients 2002

CROSS REFERENCES:

Hospitalwide Policy and Procedure
25-08 Management of Parenteral Nutrition

Nursing Policy and Procedure
J 6.0 Intravenous Infusion
J 7.0 Central Venous Access Device (CVAD) Management
J 7.1 Peripherally Inserted Central Catheter (PICC) Management

Revised: 2006/01, 2011/11/29, 2015/01/16, 2016/09/13, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

CAST CARE

POLICY:

1. Any nursing staff member (LN, CNA, or PCA) may provide care to a resident with a cast.

2. A Registered Nurse (RN) must monitor and assess the cast and extremity every shift or as ordered by Physician for complications.

PURPOSE:

To identify cast-related skin and neurovascular abnormalities related to improper cast fit or maintenance and to prevent cast deterioration.

DEFINITIONS

1. **Cast:** supportive splints made of plaster, fiberglass, or other materials that surround and immobilize an injured extremity (i.e., limb, bone or joint) to protect it from further injury, provide alignment of a fracture by holding the bone fragments in reduction and alignment during the healing process, and promote comfort.

    a. **Plaster cast:** cast made from rolls of dry muslin (i.e., loosely woven cotton). A thin layer of cotton or synthetic material is applied to the skin to prevent direct skin contact with the plaster cast material. This type of cast is heavier than a synthetic cast.
    b. **Fiberglass cast:** cast made from rolls that are wrapped around the affected body part after being activated by water or light. A protective layer of cotton or synthetic material is placed between the skin and the fiberglass cast.
    c. **Synthetic cast:** cast materials include fiberglass impregnated with polyurethane resin (cotton-polyester material) and synthetic materials that contain a stretchy polyester backing that allows for better molding to body contours and reduces the chance that the cast will be applied too tightly. The cast is lightweight, radiolucent and waterproof.

2. **Cast window:** used to detect and prevent pressure injuries, examine open wounds, and relieve pressure over external fixation devices.

3. **Types of casts:**

    a. **Sugar-tong splint:** commonly used in wrist injuries or when acute injury results in swelling of the injured part.
    b. **Short-arm cast:** commonly used for wrist or metacarpal injuries. Normally extends from the distal palmer crease to the proximal forearm.
    c. **Long-arm cast:** used for stable forearm or elbow fractures. It is similar to the short-arm cast but extends to the humerus.
    d. **Short-leg cast:** usually extends from the base of the toes to the inferior knee.
    e. **Long-leg cast:** usually extends from the base of the toes to the gluteal crease or groin.
    f. **Body-jacket cast:** used to support stable spinal injuries of the thoracic and lumbar spine.
    g. **Single-hip spica:** commonly used in stable femoral fractures and to immobilize the affected limb and trunk.
    h. **Double-hip spica:** applied to both of the lower extremities and the trunk.

PROCEDURE:

A. FOR NEWLY APPLIED CASTS

1. While the cast is still in the process of drying:
   a. Casts are usually not strong enough to bear weight for approximately 24 – 72 hours and until the cast has hardened completely.

      i. Plaster cast: requires 24 - 48 hours to dry and harden. The case will appear smooth and white after it hardens. The resident must be careful during this period because the plaster might break or crack while it is hardening. Plaster casts require approximately 24 hours for a regular arm cast and up to 48 hours before weight bearing or external pressure can be applied, and 36-72 hours for large body casts
      ii. Fiberglass cast: allows the resident to immediately apply body weight to the affect area. The cast will appear rough after it has dried.
      iii. Synthetic cast: sets in approximately 15 minutes and can withstand pressure or weight-bearing after 20 minutes.

   b. The cast must be exposed to air to dry properly and be well supported on firm surfaces. Never cover a fresh cast.
   c. The resident should be turned regularly to promote even drying of the cast.
   d. Avoid direct pressure to the cast during drying time. Use an open palm to handle the cast to prevent denting the cast (e.g., with fingerprints).
2. Keep the injured arm or leg elevated for 1-3 days after the cast or splint is applied.
3. Apply ice in a plastic bag or via an ice pack to the cast or splint at the site of the injury for 15 - 30 minutes at a time as needed.

B. MONITOR THE CASTED AREA CLOSELY

An RN will assess the cast and extremity every shift and immediately report to the physician if abnormalities are found. It is important to address abnormalities promptly because they can be due to ischemia and/or nerve compression that can results in compartment syndrome, palsy, ischemic myositis, pressure necrosis, and other severe complication

1. Monitor circulation, sensation and motion (CSM):
   a. Circulation (cardiovascular):
      i. Inspect the color of the fingers or toes on a casted extremity. Cool, discolored (e.g., pale, gray, blue), or swollen digits indicate impaired blood flow.
      ii. Test capillary refill time in the fingernails or toenails on a casted extremity; normal capillary refill time is < 2 seconds
      iii. Palpate the skin around the cast for warmth or coolness. Palpate for distal pulses.
   b. Sensation (neurovascular):
      i. Inquire about sensation in uninjured portions of the extremity (e.g., ability to feel palpation and temperature, ability to distinguish between sharp and dull objects).
      ii. Ask the patient if he/she has paresthesias (abnormal sensation, numbness, or tingling), paralysis, pain or anxiety.
   c. Motion:
      i. Test the resident’s ability to move the fingers or toes on a casted extremity.

2. Compartment Syndrome: a rare but potentially life- or limb-threatening complication that can if swelling occurs under the cast. Compression of the nerves and blood vessels of the extremity under the cast can result in permanent nerve and tissue damage within 24 hours if the pressure is

not relieved. Signs and symptoms of compartment syndrome include severe/intense/unrelieved pain, paresthesia, pallor, paralysis, and diminished pulses in the casted extremity. If signs and symptoms of compartment syndrome are suspected, notify the physician immediately (medical emergency).

3. Monitor for signs of infection (e.g., elevated temperature and heart rate). Fever, foul odor, drainage, pain, or a heat/burning sensation under the cast may indicate infection. The cast will need to be removed or windowed to allow treatment of infection.
4. Monitor for signs of bleeding (e.g., elevated heart rate, decreased blood pressure).
5. Observe for skin redness, irritation or excoriation around the edge of the cast, which can indicate chafing of the skin. If irritation is seen, small pieces of adhesive tape (petals) may be applied to the edges of a dry cast to prevent further skin irritation:

    a. Cut multiple 7.5 – 10 cm (3 – 4 in) strips of water proof tape.
    b. Use scissors to cut a round or petal-shaped edged on each strip.
    c. Place the non-rounded end of the strip inside and against the cast until half the length of the strip has been inserted.
    d. Apply pressure to secure the strip.
    e. Wrap and secure the remainder of the strip over the outer edge of the cast.
    f. Overlap additional strips around the entire cast edge.

6. Assess for resident reports of pruritus (itchiness) on skin beneath the cast. Interventions to relieve pruritus include using a blow dryer set to “cool” to blow air under the cast, and administering prescribed antihistamines. Instruct the resident to avoid inserting any object to scratch under the cast, applying powder or lotion to the skin beneath the cast, hitting or kicking an item with the cast, or self-removing the cast under any circumstance.
7. Swelling can occur soon after injury, create pressure in the cast, and cause neurovascular compromise. Methods for reducing swelling include:

    a. Elevate the extremity
    b. Exercise the affected extremity by moving the uninjured fingers or toes.
    c. Rechecking the extremity at regular intervals for a reduction in swelling after the interventions.

8. In the presence of a body jacket or spica:

    a. Superior Mesenteric Artery (SMA) syndrome (“cast syndrome”): Rare but severe complication in which the cast compresses the duodenum between the superior mesenteric artery and the abdominal aorta. This can result in an abdominal obstruction and place the resident at risk for gangrene. Signs and symptoms of SMA syndrome include feeling fullness, pain or pressure in the abdomen, nausea, vomiting, abdominal distension, and diminished bowel sounds.
    b. Assess respiratory status, bowel and bladder function, and bony prominences (especially iliac crest).

C. CAST CARE

Licensed Nurses may teach cognitively intact residents how to care for and how not to abuse cast, as well as, how to identify and report potential problems for immediate attention.

1. Keeping Cast Dry and Clean

    a. Showering or bathing:

i. Plaster cast: must be kept dry at all times and cannot get wet because excessive moisture can cause the material to warp and disintegrate. Notify the physician if the cast does not dry or the skin underneath the cast becomes wet.
   1. The resident with an extremity cast may take a shower if the cast is covered by a plastic bag secured to prevent water from entering.
   2. When taking a tub bath, an upper extremity cast must be kept out of water.
   3. If the cast is soiled from stool, clean by using a damp cloth and a mild cleanser for slight soiling (do not wet cast).

ii. Fiberglass cast: casts are waterproof. If the padding underneath the cast is also waterproof, the resident can get the cast wet (e.g., shower). Using a spray nozzle or flexible shower head to wash or rinse the inside of the fiberglass cast with warm water may reduce the odor and irritation and improve the overall skin condition of the cast area. The cast must be thoroughly dried after wetting. Lightly towel off excess water and use a hairdryer on cool or low setting to dry the inside of the cast. Do not cover the cast while it is drying.

iii. Synthetic casts: Manufacturer instructions indicate if the specific cast material can get wet.

b. Powders and lotions may only be used outside the cast. Powder inside a cast can cake and cause sore areas.

2. Repositioning Resident:

a. Notify the physician is the cast breaks, cracks, develops soft spots, becomes too loose, becomes badly soiled, develops foul odor under the cast or if an object gets stuck inside the cast. Notify the physician if the patient develops a fever.
b. Lift the cast by supporting the joints above and below the casted area to prevent injury to underlying soft tissues.
c. If only one leg is casted, turn resident toward the uncasted leg. Turn the body simultaneously to prevent undue pressure by the cast at the groin.
d. When using a sling for an upper extremity cast, ensure that the axilla well-padded to prevent skin excoriation and pressure on the neck.
e. In the presence of a body cast or spica, never use the separation bar (abduction bar) to assist with turning or moving the resident.
f. Use a fracture bedpan to promote comfort and ease of movement on and off the bedpan.
g. Perform the following for patients with a spica or body cast:

i. The edges of the cast should be covered when eating to prevent crumbs from getting inside the cast.
ii. The stabilizer bar should not be used when repositioning.
iii. The patient may lay on the stomach with a pillow under the legs, on the back with the head of the bed at 30 degrees or propped on the side with pillows.

D. EXERCISING THE RESIDENT IN A CAST

A resident with a cast should be taught to tense or to contract muscles without moving the joints.

1. If the resident is in a long leg cast, place your hand under the knee and instruct the resident to "push down."

2. If the resident is in an arm cast, instruct him to "make a fist."

3. Instruct the resident to actively exercise his fingers or toes frequently when in an arm cast or leg cast, respectively.

4. Encourage active range of motion (ROM) to the unaffected limb to prevent stiffness.

E. REPORTING AND DOCUMENTATION:

1. Interdisciplinary Progress Notes:
   Document CSM and skin observations and report to physician any abnormal findings.

2. Resident Care Plan: Thee care plan for a resident in a cast should include type of cast, mobility interventions, coping with mobility impairment, risk of complications and other individual cast care needs.

3. DNCR: The CNA or PCA shall record and report any skin changes, increased motion within the cast, sensation changes or resident reports of pain

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