# List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on October 10, 2023

| Status | Dept. | Policy # | Title | Owner/ Reviser | Notes |
|---|---|---|---|---|---|
| **New Hospital-wide Policies and Procedures** | | | | | |
| **New** | _LHHPP | 70-07 | Custom Wheelchairs | **D. Swiger** | New policy |
| **New** | _LHHPP | 27-08 | Safe Resident Handling | **D. Swiger** | New policy |
| **New** | _LHHPP | 27-09 | Splint Brace Care Management | **D. Swiger** | New policy |
| **New** | _LHHPP | 27-10 | Transfer Techniques | **D. Swiger** | New policy |
| **Revised Hospital-wide Policies and Procedures** | | | | | |
| **Revised** | _LHHPP | 22-05 | Handling Resident's Property and Prevention of Theft and Loss | | 1. Added g. Within 30 days following the death of a patient/resident, except in a coroner or medical examiner case, all money and valuables of that patient/resident which have been entrusted to the licensee shall be surrendered to the person responsible for the patient/resident or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient/resident without known heirs dies, written notice within five working days, shall be given by the facility to the public administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be available in the facility for review by the Department. |
| **Revised** | _LHHPP | 24-02 | Promoting/Maintaining Resident Dignity | **J. Wade** | 1. Added "in all areas where care may be provided. This includes but is not limited to a resident's room, the great room, or any area where the resident is agreeable to receive care. This shall be specified in the resident's care plan as their preference."<br>2. Added "13. LHH supports patient privacy/dignity during medication administration by pulling curtains in room or closing room door prior to administering medications or confirming with the resident that they prefer to not have the curtain pulled and/or the door closed. The resident's care plan shall specify their preferences." |
| **Revised** | _LHHPP | 24-10 | Coach Use for Close Observation | **A. Michaud** | 2.Added "refraining from the following".<br>3.Deleted "(Focused Review)".<br>4.Added "identify and report physical changes such as alterations in gait that may increase risk of falls, changes in urination and bowel patterns, changes in skin, level of weakness, and vital signs. They shall also report any observable non-physical changes in demeanor, appetite, sleep patterns, increased confusion or agitation, and reports of pain and document their observations, as well as any potential antecedents and interventions via the EHR."<br>5.Deleted "document their observations of the resident's behavior and any interventions each shift via EHR."<br>6.Deleted "Observations documented via EHR shall be incorporated in the LHH Nursing Weekly Summary by licensed nurse."<br>7. Added "who are assigned as coaches".<br>8. Replaced "every shift" with "regularly"<br>9. Added "EHR to include any changes reported by coaches"<br>10. Added "any new" and " ongoing" |
| **Revised** | _LHHPP | 24-18 | Resident Locator System | **T. Dentoni** | 1. Added "f. If the resident's condition improves and the AeroScout tag is discontinued based on the RCT's determination, the resident and the decision maker will be notified. The notification will be documented in EHR."<br>2. "g. If an AeroScout tag is needed to be reapplied based on the RCT's determination, a new consent will be obtained. This also applies to a readmission after a 7-day bed hold has been loss." |

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| **Revised** | _LHHPP | 25-15 | Medication Administration | **D. Smith** | 1. Added "Support patient privacy/dignity by pulling curtain in room or closing room door prior to administering medications, or confirm with resident that they prefer to not have the curtain pulled and/or the door closed and has care plan specifying this preference"<br>2. Added "a. If administering medication(s) in community or common area, such as the great room, confirm with resident they would like to receive medications in that area and resident has care plan specifying preference/acceptance of receiving medications in the community area."<br>3. Added "either" and "or the yellow and white pharmaceutical waste bin".<br>4. Added "Hospital Wide Adoption: 2023/13/06 as 25-15 Medication Administration Revised: (Year/Month/Day)" |
| **Revised** | _LHHPP | 27-01 | Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir | **D. Swiger** | 1. Fixed formatting |
| **Revised** | _LHHPP | 27-05 | Tracheostomy Management | **M. Healy** | 1. Deleted "speak valve (e.g., Passy Muir Valve [PMV]" and "Tracheostomy Speaking Valve: Interdisciplinary Protocol for U se of the Passy Muir."<br>2. Deleted "This needs to be aligned with updates on Rehab Referral P&P"<br>3. Deleted " The results of the screening evaluation shall be documented in the Speech Pathology section of the electronic medical record"<br>4. Deleted "This is spelled out in LHHPP 27 01 that is referenced in 3a."<br>5. Added "and Laryngectomy<br>6. Deleted "Procedure: Care and Cleaning of the Laryngectomy Tube"<br>7. Deleted "A laryngectomy tube has 3 parts, outer tube or cannula, inner tube or cannula and obturator. These are also laryngectomy plastic/rubber tubes that can also be used. This tube is used to keep the airway patent."<br>8. Deleted "A spare laryngectomy tube that is being used for the resident should be kept at bedside for emergent replacement in the event the tube is dislodged."<br>9. Deleted " Cleaning and Care: a. Obtain equipment and items needed for cleaning procedure. This should include a Tracheostomy cleaning kit, Tube Tie, gauge etc. Explain procedure to patient/resident."<br>10. Deleted "b. Remove the Laryngectomy tube to be cleaned. Inspect the area around the stoma and wall of the trachea for mucus or crusts of secretions that might have formed between cleanings."<br>11. Deleted "c. Using gauze dampened in saline to clean the stoma area and dry. d. Clean the tube using the brush provided in the tracheostomy cleaning kit. Clean each part of the tube if it is that design. Use saline for cleaning and rinsing. Shake off any extra water/saline. Insert the obturator, if applicable."<br>12. Deleted " Lubricate the tip of the tube with water-soluble jelly. Insert the tube into the Stoma. Do not tilt the head back as this may narrow the stoma. f.. |
| **Revised** | _LHHPP | 70-01 C3 | Earthquake Response Plan | **T. Rivera** | 2. Added "N" to "HICS"<br>3. Replaced "outage" with "incident"<br>4. Added "staff" and "already"<br>5. Added " Do not"<br>6. Added "Any medis or public information inquiries should be routed to the LHH Communications Team via the NHICS team."<br>7. Deleted "ONLY with the approval of the LHH CEO or DPH Public Information Officer (PIO)"<br>8. Deleted "safe, quality"<br>9. Deleted "Employees shall refer media representatives to the Hospital Incident Command Center at 415 759 4636"<br>10. Added "(residents and staff)" and "and respond per R.A.C.E. as needed. |

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| | | | | | 1. Replaced "Hospital" with "Nursing Home"<br>2. Added "N" to "HICS".<br>3. Added "Response staff and NHICS team can use the CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities document as a reference for additional response actions."<br>4. Added "300,000-gallon" and "(details with material management). "<br>5. Replaced "190 gallons of water stored in the kitchen (60 cases of 24 1/2 liter bottles)" with "270 gallons of water stored in Food Service Emergency Storeroom (120 cases of 24 can, 12 ounces per can). "<br>6. Replaced "164 gallons of juice, soda and flavored water in kitchen (includes 20 cases of frozen 4 oz juice, 94/ case; 25 cases of 24 12 oz soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz each)." with "325.5 gallons of juice stored in the Food Service Emergency Storeroom "<br>7. Deleted "Apple Juice 64 cases 48 ea./4 ounce, Diet Cranberry Juice 69 cases 48 ea/ 4 ounce, Orange Juice 84 cases 48 ea/4ounces."<br>8. Replaced "Need parameters: typical is if its yellow, let it mellow if its brown flush it down. Gross but works." with "only flush for solid waste."<br>9. Replaced "Use alcohol hand sanitizer for hand washing." with "Hand hygiene will remain a priority. Encourage alcohol hand sanitizer use unless hands are visibly soiled, or staff are caring for a resident with known/suspected CDI infection."<br>10. Deleted "Minimize" and "as directed by command center/ infection control ranch to maintain infection control and safety and "<br>11. Added "will remain a priority" and commercially prepared"<br>12. Added ",via facilities,"<br>13. Added "CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities" |
| **Revised** | _LHHPP | 70-01 C8 | Water Disruption Plan | **T. Rivera** | |
| **Revised** | _LHHPP | 76-02 | Smoke and Tobacco Free Environment | **M. Antoc** | 1. Added "The RCT shall ensure that residents identified, via the required smoking assessment, to have the need for safety equipment (i.e., smoker's apron) will be provided one. These protective devices will be documented and incorporated in a written plan of care that includes monitoring of compliance and effectivity."<br>2. Added "Smoker's aprons will be available to residents in the designated smoking area."<br>3. Added "For residents who refuse to utilize the identified safety equipment required for their safety while smoking, the residents shall not be provided smoking materials (i.e., cigarettes) in the designated smoking area."<br>4. Added "Residents who continue to not comply with the terms of this policy shall receive education on the requirements of the facility policy."<br>5. Added "Residents may risk being deemed not safe to smoke in the designated smoking area and smoking materials shall not be provided. " |
| **New Nursing Policies and Procedures** | | | | | |
| **New** | Nursing | | Laryngectomy Tube Care | **J. Selerio** | New policy |
| **New** | Nursing | | Change of Shift Hand-Off (Nursing) | **K. MacKerrow** | New policy |
| **Revised Nursing Policies and Procedures** | | | | | |
| **Revised** | Nursing | B 5.0 | Resident Identification and Color Codes | **J. Selerio** | 1. Updated to indicate consistent system of stickers to be placed on 1{) Bed Card 2) Hallway 3) Mobility Devices<br>2. Removed wristbands section<br>3. Included documentation in care plan of any refusals by residents<br>4. Updated chart |
| **Revised** | Nursing | I 3.0 | Tracheostomy Care | **J. Selerio** | 1. Added: "Tracheostomy site care should be performed daily and PRN. Site assessment should be performed and documented Qshift to determine status of dressing"<br>2. Added "outer cannula standard" to clarify the outer cannula trach tube replacement to be done once per month<br>3. Removed "ward physician" and added that LN to stay with resident and attempt to open airway for dislodged tube<br>4. Sterile solution to be single use only and discarded after each use<br>5. Trach care changed to be done daily and prn |
| **Revised** | Nursing | K 9.0 Att 1 | Coordination of Care for Residents on Hemodialysis | **J. Selerio** | Updated documentation guidelines to include completion of Communication Form in HER |
| **Revised Food and Nutrition Services** | | | | | |
| **Revised** | FNS | N/A | Diet Manual | **L. Cecconi** | Updated Diet Manual |
| **Revised** | FNS | 1.11 | Nutritionally Adequate Menus | **L. Cecconi** | Minor grammatical changes |

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| **Revised** | FNS | 1.12 | Registration of Dietitians | **L. Cecconi** | Minor grammatical changes |
| **Revised** | FNS | 1.13 | Drug Food Interactions | **L. Cecconi** | Minor grammatical changes |
| **Revised** | FNS | 1.15 | Diet Manual Approved by Medical Staff | **L. Cecconi** | Updated language with current process for approval |
| **Revised** | FNS | 1.16 | Nutrition Screening and Assessment Documentation In the Electronic Health Record (EHR) | **L. Cecconi** | Revised title to Nutrition Screening and Documentation Process. Revised for updated process and best practice for documentation. Referenced current updated Standards of Practice for Clinical Nutrition |
| **Revised** | FNS | 1.19 | Acute Medical/Rehab Admissions/Transfers | **L. Cecconi** | Updated language with current process |
| **Revised** | FNS | 1.2 | Nutrition Screening and Assessment Documentation for Acute Hospital Admissions in the Electronic Health Record | **L. Cecconi** | Revised title to omit EHR and made minor grammatical changes |
| **Revised** | FNS | 1.22 | Enteral Formulas Availability | **L. Cecconi** | Revised title with minor grammatical changes |
| **Revised** | FNS | 1.23 | Discharge Diet Instruction | **L. Cecconi** | Updated language with current process |
| **Revised** | FNS | 1.25 | NPO or Clear Liquid Diet Greater than three days | **L. Cecconi** | Revised title and updated language with current process |
| **Deletion Food and Nutrition Services** | | | | | |
| **Deletion** | FNS | 1.17 | Nutrition Assessment as part of the care plan process | **L. Cecconi** | Combined into 1.16 |
| **Deletion** | FNS | 1.18 | Nutrition Screening & Assessment | **L. Cecconi** | Obsolete & redundant |
| **Deletion** | FNS | 1.21 | Palliative Nutrition Care | **L. Cecconi** | Obsolete and N/A |
| **Deletion** | FNS | 1.24 | Care Plans to Address Nutrition Problems | **L. Cecconi** | Redundant and language combined with 1.16 |

# New Hospital-wide Policies and Procedures

# CUSTOM WHEELCHAIRS

## POLICY:

Custom wheelchairs may be ordered for residents with specialized positioning and seating needs who cannot be safely and adequately positioned in a facility wheelchair, provided a funding source is identified. The funding source must be able to pay for ongoing maintenance and repairs.

## GOAL:

1. Resident will be able to maintain highest functional level of mobility skills and overall Quality of Life (QOL).
2. Resident will be optimally positioned when up in a wheelchair to participate in functional tasks for QOL.

## INCLUSION CRITERIA:

Residents may be considered for custom wheelchairs based on medical necessity and upon the recommendation of the Occupational Therapist/Physical Therapist. The resident must also meet one of the following criteria:

1. A physician's order for a wheelchair evaluation, and a subsequent Occupational Therapy/Physical Therapy evaluation or assessment confirms that proper seating and mobility cannot be achieved with available equipment. For power wheelchairs, the patient must demonstrate the ability to drive and operate the power wheelchair independently.

2. A resident cannot be easily transported to activities in a facility provided wheelchair due to positioning needs.

3. A custom wheelchair is needed for discharge to the community to enable mobility, completion of activities of daily living, or vocational activities and overall QOL.

4. When specific components are needed to position residents to reduce current contractures.

5. A resident has a history of positioning problems. The Occupational/Physical Therapist is unable to position resident safely and adequately in available wheelchairs. Criteria may include, but is not limited to:

    a. Supporting midline orientation.
    b. Providing normal visual access to the environment.
    c. Enabling adequate respiration.
    d. Enhancing ability to swallow or improving ability to perform self-feeding.
    e. Protecting a resident from injury (e.g., due to movement disorders).

f. Reducing risk of falls to floor due to lateral, posterior, or anterior flexion.

g. Reducing slides from chair due to posterior tilt or trunk extension.

**PROCEDURE:**

1. If a resident meets any of the criteria for a custom wheelchair, a physician may request for an Occupational Therapy/Physical Therapy evaluation for a functional mobility evaluation through the electronic health record (EHR).

2. On receipt of the physician's order, the Occupational/Physical Therapy Department will conduct an evaluation or assessment of the resident's custom wheelchair needs.

3. Adjustments or modifications may be made to a personal wheelchair, or a facility owned custom wheelchair, pending wheelchair parts and/or insurance to meet the resident's needs.

4. If a wheelchair cannot be modified, a trial with an appropriate custom wheelchair (if available from a vendor or from the Rehabilitation Department) will be conducted to see if it will benefit the resident's condition.

5. If a facility wheelchair and positioning devices are unable to meet a resident's highest functional independence and/or are unable to meet their positioning needs, and a trial of a custom wheelchair has demonstrated medical benefit, the Occupational/Physical Therapist will:

    a. Communicate the assessment or evaluation with the Resident Care Team and/or document in the resident's medical record, the outcome of any trial of the equipment.

    b. Consult with vendor(s) for evaluation of an appropriate custom wheelchair for the resident.

    c. The Occupational/Physical Therapist will facilitate the procurement process and assist with completing and/or obtaining the required forms regulated by specific insurance requirements (i.e. Medi-Cal or Medicare) from the prescribing physician, as needed.

    d. Identifying an appropriate funding source and submit the required documentation to the vendor.

    e. Consider the following when completing the medical record documentation for skilled seating evaluations:

        i. Intervention(s) that were tried by Nursing staff and/or rehabilitation department;

        ii. Functional deficits due to poor seating or positioning;

        iii. Most recent prior functional level;

        iv. Postural deficits the patient is unable to self-correct;

v. Recent event(s) that prompted a seating evaluation;

vi. Specific wheelchair, specialty items, dimensions and/or specific cushions that were evaluated and/or recommended;

vii. A clear explanation of how the proposed custom wheelchair or seating device will make a significant improvement in functional abilities versus current wheelchair or seating device;

viii. Transition to caregiver follow-up.

6. If the resident's insurance denies a custom wheelchair while the resident is residing at LHH, the resident will remain in the facility provided wheelchair.

7. If the resident receives a custom wheelchair, the licensed nurse shall document the make, model, and serial number in the designated unit records per resident inventory.

8. For repairs of custom wheelchair on loan from Laguna Honda Hospital Rehabilitation Department, a quote for the repair will be obtained from a vendor and submitted to the supervisor for approval. If the cost of repair is approved, the therapist will contact the vendor to have the parts ordered and schedule for a follow up visit to complete the repair.

- **Nursing/Unit staff will**:

1. Monitor residents' needs and relay this to physicians for a Rehab referral for a wheelchair evaluation if needed.

2. Refer to the vendor: The most recent custom wheelchair issued to resident by insurance requiring repairs are referred to the vendor who supplied the wheelchair or vendor of resident's choice. Vendors will be contacted by nursing/unit staff to repair personal custom wheelchairs. This may be dependent on insurance approved vendors. Vendor availability is subject to each company and not related to LHH staffing.

3. Address resident's needs and submit work order to Facilities department to obtain a facility wheelchair and/or facility chair repairs (Refer to LHH EM -b0: Manual Wheelchair Maintenance and Repair).

4. Submit a work order to LHH Facilities for custom wheelchair repairs that do not affect the integrity or warranty of the wheelchair. This is subject to LHH facility discretion (i.e., inflating air into tires, tightening a screw).

5. Place work order for maintenance or repair of residents own or loaned w/c not provided by insurance or LHH. A work order can be placed to LHH facilities. If LHH facilities is not able to repair the w/c, resident or nursing/unit staff can contact an outside vendor if the resident would like to self-pay for the repairs/maintenance.

**ATTACHMENT:**
**None**

**REFERENCE:**

1. Barclays California Code of Regulations, Title 22 § 51303(a – i).

2. Barclays California Code of Regulations, Title 22 § 51321

3. Physical Therapy, Occupational Therapy and Speech-Language Pathology Outpatient Services Educational Update, United Government Services (fiscal intermediary), 2nd Revision, November 2003.

4. LHH EM -b0: Manual Wheelchair Maintenance and Repair.

5. California Advocates for Nursing Home Reform: Access to Durable Medical Equipment in Nursing Homes. Retrieved on 7/18/2023 from http://www.canhr.org/publications/newsletters/Advocate/FrontArticle/adv_2001_4.htm

Most recent review: 17/07/31, 20/04/27, 21/07/22, 22/04/21, 23/05/16
Revised: 04/03/29, 04/08/18, 10/10/21,16/08/05, 18/08/14, 20/05/21
Original Adoption: 99/08/23

# SAFE RESIDENT HANDLING

## POLICY

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to a policy of safe resident handling for the prevention of musculoskeletal injuries attributable to resident mobilization among LHH healthcare workers.

## PURPOSE

1. To implement procedures for safe resident handling consistent with Title 8 of California Occupational Health and Safety Administration (Cal-OSHA), and LHHPP 73-01 Laguna Honda Injury and Illness Prevention Program.

2. To establish a process for assessing resident mobility needs and to determine safe resident handling procedures.

3. To establish procedures to minimize hazards of manual resident handling using appropriate equipment, personnel, and training.

## DEFINITIONS

1. Resident Mobilization: putting into movement or assisting in the putting into movement, part or all of a resident's body.

2. Manual resident handling: lifting, transferring, repositioning, or mobilizing part or all of a resident's body done without the assistance of equipment including but not limited to use of gait belts (Refer to Appendix B: Gait Belts FAQs).

3. Equipment: a powered or non-powered device that effectively reduces the forces exerted by or on employees while they perform resident handling activities.

4. Musculoskeletal injury: acute injury or cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, bone, or blood vessels.

## PROCEDURE

### 1. Control Strategies/Prevention Techniques

a. A registered nurse (RN) shall complete an initial and ongoing assessment regarding the resident's ambulation needs and assistive devices required. The RN shall communicate with the resident care team and maintain documentation of ambulation needs, devices and preferences on the resident care plan in accordance with the NPP D6 5.0 Ambulation Policy. Rehab staff may be referred to as per physician order, and may participate in the resident care team, and/or resident care conference meetings when resident is on rehabilitation services to address residents' mobility needs including but not limited to, transfers and ambulation.

b. Employees shall use assistive devices during resident mobilization in accordance with the resident care plan including but not limited to use of gait belts as per resident's care plan. Devices available to Laguna Honda employees are listed in Appendix A.

c. Although employees are encouraged to do their best to prevent residents from falling, employees are not expected to catch a resident who is falling due to the risk of injury to the employee.

d. The Facility Services Department shall maintain the mechanical lifts on nursing floors.

e. The Nursing Department shall submit work orders to Facility Services for equipment repairs and/or replacing damaged equipment and shall order any new equipment deemed necessary for safe resident handling.

f. Charge Nurses shall update assignment sheets and care plans to communicate the need for buddy system for safe resident handling.

g. Employees shall use their assigned buddy for assistance if the resident care plan states the need for a two person assist or as needed.

h. Any employee who experiences a resident handling injury shall report according to procedures listed in LHHPP 73-01 Injury and Illness Prevention Program.

**2. Education and Training**

a. All new employees receive training during new employee orientation on:

i. LHH Injury and Illness Prevention Program

ii. Employees right to refuse unsafe work unless proper training is provided

iii. Recognizing musculoskeletal pain as a workplace injury.

b. All new employees with resident care responsibilities shall attend health and safety orientation provided by the Department of Workplace Safety and Emergency Management (WSEM) that includes the following topics:

i. LHH Ergonomics Program

ii. Recognizing and reporting musculoskeletal injuries that result from resident handling tasks.

iii. Hazards and risk factors associated with poor ergonomics during resident mobilization including lifts, transfers and repositioning.

iv. Other risk factors for injury such as patient size, mobility, willingness to cooperate and clinical conditions

v. Injury prevention methods including equipment, proper body mechanics and buddy system.

vi. Hands on training on operating powered and non-powered assistive devices including mechanical lifts, ceiling lifts, gait belts, transfers.

c. All employees with resident care responsibilities shall complete online annual refreshers that review topics covered in the initial training. WSEM contact information is provided for questions.

d. All Nursing Department employees with resident care responsibilities are evaluated on their ability to demonstrate the use of assistive devices initially and annually using a competency checklist. If employees fail to successfully demonstrate these skills, additional training shall be provided.

e. Records of training shall be maintained by the Education Department and WSEM.

3. Program Administration and Maintenance WSEM is responsible for the overall administration and maintenance of the Safe Resident Handling Program, for the tracking and analysis of resident handling incidents, and for eliciting the input of employees in making improvements to the program. WSEM shall also collaborate with Education and departments providing resident care (e.g., rehabilitation services) to develop and deliver educational programs for staff on strategies and procedures to minimize the risk of musculoskeletal injuries associated with resident handling.

## ATTACHMENT

Appendix A:
Assistive Devices Available for Safe Resident Handling
REFERENCE:
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 73-15 Ergonomics Program
NPP D6 1.1 Battery Operated Lift Transfer
NPP D6 1.4 Battery-Operated Ceiling Lift
NPP D6 2.0 Transfer Techniques
NPP D6 5.0 Ambulation Policy
Original adoption: 19/03/12 (Year/Month/Day)

Appendix A:
Assistive Devices Available for Safe Resident Handling
1. Mechanical Lifts
2. Ceiling Lifts
3. Slide Sheets
4. Gait Belts
5. Slide Boards
**Images in policy

Appendix B: Gait Belts FAQs

## Appendix A: Gait Belt FAQs

1. What is a gait belt?
    a. Gait belts are thick fabric or vinyl belts that give staff a place to hold onto the resident to assist with balance and support of the resident. Contact your supervisor for location of gait belts on your unit.
    b. Why should you use a gait belt?
    c. Gait belts should be worn to ensure safe mobility for resident and staff.
    d. Who should use a gait belt?
    e. Every staff member that assists resident with mobility, including transfers and ambulation, provided resident meets inclusion criteria for gait belt use. Criteria for assessing use of gait belts with transfers, as follows, but not limited to:
        i. Inclusion Criteria:
            1. Level of assist requires hands on or physical assist
            2. Due to resident related factors, resident require supervision and/or stand by assist for safety.
        ii. Exclusion:
            1. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.
            2. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

1. Where should you place a gait belt?
    a. Most gait belts are placed at the waist level. Some residents have injuries, surgery, drainage, and tubes that require the belt to be placed higher or lower than waist level.
2. When should you use a gait belt?
    a. Gait belts should be worn every time you assist a resident with mobility!!! Exceptions to this are the following:
        i. Exclusion Criteria:

1. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

2. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

3. Gait belts should be worn in resident's room, in the halls if ambulating, or any place resident will need to transfer from one surface to another.

4. How do you use a gait belt?

    a. Refer to Gait Belt Competency.

**Reference:**
Institute for Healthcare Improvement. How to Guide: Reducing Patient Injuries from Falls. (December 2012).

# SPLINT/BRACE CARE MANAGEMENT POLICY

## POLICY

To ensure compliance with Centers for Medicare and Medicaid Services (CMS) Regulations when providing individualized care to meet residents' needs with physician orders for splints and braces.

## GOAL

To ensure all residents' needs are met through a multidisciplinary evidence-based resident-centered care approach and compliance with the resident's individualized plan of care respectively, in order to, attain, maintain, enhance, and achieve overall residents' quality of life (QOL).

## DEFINITION

1. Splints: A splint or a brace can immobilize and protect joints, reduce pain, decrease swelling, and facilitate healing of acute injuries. It is a type of orthotic device that supports or corrects musculoskeletal deformities or abnormal, treat contractures, as well as to alleviate other joint problems. Splints or Braces are used to do as follows, but not limited to:
    a. Improve alignment
    b. Prevent skin breakdown
    c. Prevent deformities and contractures of the joints
    d. Protect the joints during activities
    e. Promote healing
    f. Position joints in good alignment during rest
    g. Relieve muscle strain around weak joints
    h. Relieve pain
    i. Maintain and improve mobility and ROM
    j. Increase ability to use arms and legs functionally

## PROCEDURE

1. Splint or Brace management care recommendations and instructions may include, but not limited to: *Any deviations from the following must be reported and documented by nursing staff to charge nurse and/or nurse manager immediately.*

    a. Prior to applying the Splint or Brace:

        i. Monitor for swelling, bruising, and skin irritation

        ii. Be sure the skin is clean and dry

iii. Perform range of motion or stretching exercises, if prescribed as per rehabilitation services, prior to splint or brace application

iv. Ensure splint or brace is clean prior to application

v. Be gentle and ensure awareness of care plan instructions for splint or brace application, position, wearing schedule (frequency, duration)

b. When applying the splint or brace, ensure:

i. Splint or brace fits appropriately

ii. Does not dig into or rub into the skin

iii. Maintains appropriate joint alignment

iv. Allow to fit one to two fingers between the splint or brace liner and the resident's skin, and between the strap and the skin

v. Fastened correctly

c. Once splint or brace is applied, monitor resident for:

i. Skin is clean and dry under the device

ii. Ensure bony prominences are protected and padded

iii. Inspect skin for redness, edema, open areas before applying, and after removal. If present, notify charge nurse immediately.

iv. Inspect for signs of skin irritation, redness, pain, abrasions, or breakdown. If present, notify charge nurse and or nurse manager immediately.

v. Monitor for signs of impaired circulation, such as numbness, tingling, cyanosis, color or temperature changes, or edema. If present, notify charge nurse and/or nurse manager immediately.

vi. Splint or brace does not have or develop rough edges, cracks, or tears. Apply skin protector or padding, and notify charge nurse, and/or nurse manager immediately.

d. Check splint or brace for breakage, loose, or missing parts, deterioration, wear and tear. If this is identified, check with charge nurse and/or nurse manager for removal of device or discontinue of order. Nurse will alert physician to send a new order for rehabilitation services (occupational therapy/physical therapy) to address splint or

brace replacement needs. Once splint or brace is removed, ensure the following occurs:

i. Check resident skin, and note resident's complaint of pain, observe signs of pressure, red or open areas, blisters, edema, cyanosis, irritation, temperature changes, or other problems in the area of the splint or brace. Notify charge nurse and/or nurse manager immediately.

e. Nursing staff will ensure daily compliance and documentation (including but not limited to worklist and care plan updated for splint use) of splint or brace care management recommendations and instructions, and wearing schedule (frequency, duration, location, shift). Any deviations noted, will be immediately informed, and documented to the charge nurse and/or nursing manager.

f. Nursing management will ensure immediate notification and documentation of this notification, to the following, but not limited to:

i. Physician

ii. Rehabilitation Services

iii. Orthotics & Prosthetics

iv. Interdisciplinary and Multidisciplinary meetings including but not limited to: immediate notification and discussion during unit huddles or 24 hour shift report per shift discussions for all units.

g. Interdisciplinary and multidisciplinary meetings will include but not limited to:

i. Resident care team meetings/Resident care conferences will discuss current physician order for splints and/or braces and current resident outcomes and responses to the respective devices.

ii. Quality Assurance and Performance Improvement (QAPI) meetings will also discuss residents' related outcomes and compliance with use of splints and braces as per physician orders; interventions or strategies utilized to increase compliance, and ongoing concerns to address quality of resident care.

h. **Physicians** will address residents' needs in relation to any deviations reported for splints or braces care recommendations and instructions, and additional resident's needs, as indicated per resident's health care team report, and/or resident's or resident's family self-report; and document as follows, but not limited to:

i. Discontinue current physician orders, if indicated for the resident as per physician expertise

ii. Send physician orders to Rehabilitation Services and/or Orthotics & Prosthetics to address ongoing residents' needs that may impact deviation from resident's splint or brace care recommendations or instructions. Resident needs in relation to splint or brace may include but not limited to: onset of contracture or worsening contracture, skin integrity compromised, worsening pain or new onset of pain, new positioning needs or worsening positioning, resident's tolerance changes or need for modification of frequency/location/duration, and resident's need for a new splint or brace or alternative rehabilitation skilled approaches, etc.

iii. Send physician orders and/or additional communication to nursing and or other departments, as it relates to the residents' needs in relation to the resident's splint or brace care management recommendations and instructions.

i. **Rehabilitation Services** will address physician orders in relation to resident's splints as follows but not limited to:

i. As per clinical judgement, rehab staff will perform a comprehensive assessment (evaluation and/or treatment) that may include but not limited to, as follows, an analysis of resident factors, resident's functional needs and overall QOL and possible risk:

- Resident factors: primary active diagnosis, comorbidities especially in relation to peripheral vascular or neuropathy, cognition, resident behaviors and history of response or compliance to previous devices and splints and associated non-compliance or concerns.

- Possible risk/contraindications: Anatomical positioning (e.g., contractures, range of motion limitations), risk of pressure injury or skin ulcers especially with prominent bony prominences, violation of skin integrity, open wounds, risk for soft tissue injury, etc.

j. Documentation: Rehab staff will ensure all documents for evaluation, treatment daily notes, progress notes, re-evaluation, and discharge notes include the following but not limited to:

i. Provide indicator for the splint or brace and no contraindications indicated

ii. Clinical reasoning for recommendation for splint or brace to meet resident's functional needs and overall QOL

iii. Document recommendation for the splint or brace versus a trial of the splint or brace; also document who will be monitoring the resident during the trial of the splint or brace and list of items in addition to the splint or brace

recommendations or instructions for monitoring during the trial period.

iv. Document training and education provided to nursing staff and/or nursing management for the resident's splint or brace care management recommendations and instructions. Ensure nursing demonstrates compliance via teach back and visual demonstration methods for resident's splint or brace – application, monitoring during wearing, removal, documentation, awareness of risk factors.

v. At discharge and/or when the splint or brace is recommended while resident may be on therapy caseload, whichever occurs first for the resident, and requires the resident's individualized plan of care to be updated, include the following but not limited to: wearing schedule (frequency, positioning, location, nursing shift), training completed and documented with competency checked off, if applicable, resident's consent, and response, and overall benefit and consequences of compliance to the splint or brace for the resident. In addition, ensure resident's

k. Interdisciplinary/Multidisciplinary Report: Rehab staff will discuss splint or brace care management recommendations and instructions during the following, but not limited to: Rehab department resident-care meetings, unit huddles or resident care team meetings or resident care plan meetings, and QAPI meetings, to ensure compliance with CMS, and overall quality standards established by the organization to meet all residents' needs and overall QOL.

## REFERENCES:

Agency for Healthcare Research and Quality (AHRQ): Safety Program for Long Term Care.
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CMS. Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) Review. (2022).
CMS. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (2023).
Sprouse.R.A., McLaughlin.A.M., and Harris.G.D. *Braces and Splints for Common Musculoskeletal Conditions.* American Academy of Family Physicians. (2018: 98(10): 570-576).
Trivers.A., and Rebernik.D. *Contractures and Splinting.* CNA Training Advisor. (August 2014).

# TRANSFER TECHNIQUES

## POLICY

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. All residents who require battery-operated lift transfer must have their own assigned sling for transfer and bathing. Each sling must have resident's name and room number.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. Any member of nursing staff (LN, CNA, or PCA) may perform transfer procedure. Check care plan for required number of staff assistance during transfer, level of assistance, use of assistive or adaptive device including gait belt (refer to Appendix A: Gait Belts FAQs)

6. Criteria for assessing use of gait belt with transfers, as follow, but not limited to:

a. Inclusion Criteria:

1. Level of assist requires hands on or physical assist

2. Due to resident related factors, resident require supervision and/or stand by assist for safety

b. Exclusion:

- Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

- Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

## PURPOSE

To ensure resident's and staff's safety when moving the resident from one surface to another.

## PROCEDURE

### 1. Prior to Transfer

a. Review Resident Care Plan prior to transfer of resident.

## 2. Transfer Techniques

a. Slide Transfer Technique (Gurney to Bed and Vice Versa)

i. Place the gurney parallel to the bed.

ii. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.

iii. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.

iv. Set all brakes on all equipment in a “locked” position after the equipment is positioned.

v. Use a draw sheet or slider sheet to assist with transfer.

vi. Always have drainage bags lower than the area being drained.

b. Pivot transfer Technique

i. Stand in front of resident or along resident’s weak side

ii. Position resident’s feet flat on the floor

iii. Grasp gait belt at each side from underneath

iv. Brace knees against resident’s weak lower extremities

v. Use knee and foot to block the resident’s weak leg or foot, and place your other foot slightly behind you for balance or straddle your legs around the resident’s weak leg

vi. Ask resident to push down on the mattress and on the count of “3” have the resident bend and lean forward (like a see-sawing motion)

vii. *Do NOT carry resident*

viii. Assist resident to a standing position as you straighten your knees.

ix. Encourage resident to take small steps towards the chair or wheelchair if resident is able.

x. Turn resident so they can grasp the far arm of the chair or wheelchair. Legs will touch the edge of the seat.

xi. Continue turning resident until the other armrest is grasped.

xii. Lower resident into the chair or wheelchair as you bend your hips and knees. To assist, the resident leans forward and bends the elbows and knees.

xiii. Make sure resident's hips are to the back of the seat. Position resident in good alignment.

xiv. Position the resident's feet on the wheelchair footrests.

xv. Remove gait belt.

xvi. Position the chair as resident prefers and keep belongings and call light within reach.

xvii. After completing transfer, check in with the resident for any adverse effects: dizziness, pale complexion, pain, and/or decreased consciousness. Report any change in condition to the license nurse.

c. Sliding Board Transfer Technique

vii. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.

viii. Lower the bed to the same height as the seat of the chair or wheelchair.

ix. Lock all bed and wheelchair brakes.

x. Move armrest and fold wheelchair footrests back.

xi. Assist the resident in a seated position to prepare for bed to chair transfer. Place gait belt on the resident.

xii. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.

xiii. Slide the resident along the board to reach the chair.

xiv. Remove the gait belt and the sliding board.

i. Secure armrest and footrest back in position.

d. Transfer Techniques using Mechanical Lift (Refer to NPP D6 1.1 Battery Operated Lift Transfer and NPP D6 1.4 Battery Operated Ceiling Lift)

## 3. Reporting and/or Documentation

a. All care team will report and communicate to the physician and rehab staff when additional transfer training is warranted.

## 4. Documentation

a. Electronic Health Record (EHR)

i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer with/without use of assistive device or adaptive equipment and gait belt respectively.

ii. The Licensed Nurse documents weekly, monthly, and as needed resident's change in functional level and reports this during the 24-hour report, handoff for all nursing shifts, and RCT team meetings.

## 5. Care Plan

a. The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer with or without use of assistive device or adaptive equipment, and with or without use of gait belt, and the position of the device (i.e., wheelchair place on strong side).

b. All residents who require battery-operated lift transfer must be documented on the Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.

c. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry functional transfer (bed <> chair; toilet transfers; may include shower transfer).

## Appendix A: Gait Belt FAQs

1. What is a gait belt?
    a. Gait belts are thick fabric or vinyl belts that give staff a place to hold onto the resident to assist with balance and support of the resident. Contact your supervisor for location of gait belts on your unit.
2. Why should you use a gait belt?
    a. Gait belts should be worn to ensure safe mobility for resident and staff.
3. Who should use a gait belt?
    a. Every staff member that assists resident with mobility, including transfers and ambulation, provided resident meets inclusion criteria for gait belt use. Criteria for assessing use of gait belts with transfers, as follows, but not limited to:
        i. Inclusion Criteria:
            - Level of assist requires hands on or physical assist
            - Due to resident related factors, resident require supervision and/or stand by assist for safety
        ii. Exclusion:
            - Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.
            - Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.
4. Where should you place a gait belt?
    a. Most gait belts are placed at the waist level. Some residents have injuries, surgery, drainage, and tubes that require the belt to be placed higher or lower than waist level.
5. When should you use a gait belt?
    a. Gait belts should be worn every time you assist a resident with mobility!!! Exceptions to this are the following:
    b. Exclusion Criteria:

i. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

ii. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

c. Gait belts should be worn in resident's room, in the halls if ambulating, or any place resident will need to transfer from one surface to another.

6. How do you use a gait belt?

a. Refer to Gait Belt Competency.

**Reference:**
Institute for Healthcare Improvement. How to Guide: Reducing Patient Injuries from Falls. (December 2012).

# Revised Hospital-wide Policies and Procedures

# HANDLING RESIDENT'S PROPERTY AND PREVENTION OF THEFT AND LOSS

## POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) maintains each resident's right to be free from misappropriation of property. There shall be a method of accounting for and safeguarding resident's property while the resident is at LHH and until the property is safely returned to the resident or legally authorized person.

## PURPOSE:

To ensure the proper handling of a resident's personal property and valuables and to prevent loss or theft of these items.

## DEFINITION:

"**Misappropriation of property**": the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

## PROCEDURES:

### 1. General Guidelines

a. Upon admission, relocation, annually, and transfer or discharge from LHH, nursing staff and the resident and/or his/her representative shall complete an inventory of the resident's property. Inventory of the resident's property shall be recorded on a form entitled "Inventory of Resident's/Patient's Property" (Form Nos. MR311 and MR311b (hereinafter IRP).

b. The completed IRP shall be printed and signed by the resident or the resident's representative, and by a staff member on behalf of LHH. The signed document shall be scanned into the electronic health record.

   i. If the resident is unable to sign, the resident shall mark an "X" with two witnesses signing. If the resident is unable to mark an "X" then the nurse shall write, "resident unable to sign" with two witnesses signing. If the resident understands and can express consent, the nurse shall write, "resident expresses consent" with two witnesses signing.

   ii. If the resident is unable to participate in the process i.e., because of cognitive deficits, the legal representative shall sign on behalf of the resident with one witness signing. If the resident does not have a legal representative present, the nursing staff shall note that the "resident is unable to participate in the inventory process and there is no legal representative present" with two

witnesses signing.

c. A copy of the IRP shall be provided to the resident or the person acting on the resident's behalf. Thereafter, a copy of a current inventory shall be made available upon request to the resident, responsible party or other authorized representative. This can be obtained by printing the IRP from electronic health record.

d. A unit staff member shall instruct the resident and his/her legal representative to leave valuables at home or send them home with family or friends.

   i. If the resident decides to keep the valuables with him/her and not in LHH's safe, the resident may do so after signing the "Acknowledgment and Waiver" on the IRP, releasing LHH from liability for loss or damage.

e. LHH reserves the right to exclude property on the unit, such as perishables, firearm/weapons, hazardous waste, toxics, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, and/or other property that endangers the safety and welfare of others.

f. Staff shall notify the San Francisco Sheriff Office (SFSO) at LHH (ext. 4-2319) of the resident's firearms or other dangerous objects and shall document the disposition of the items in the resident's IRP.

   i. Dangerous objects shall be confiscated by SFSO at the direction of LHH staff, catalogued by LHH staff, and transported by SFSO for proper destruction.

   ii. Should there be indication that the dangerous object(s) is of sentimental value, the item(s) shall be bagged, labeled by nursing staff, and secured by SFSO for safekeeping.

g. The Admission and Eligibility (A&E) Staff and/or the neighborhood nurse shall notify the resident, on or before admission to LHH, on the number~~amount~~ of belongings that LHH can accommodate. The resident's property must fit into the bedside table and a wardrobe.

   i. The resident shall be encouraged to disclose all items for a complete inventory. If the resident refuses to have his/her property inventoried after all reasonable efforts have been made to enlist the resident's cooperation, the resident shall have a reasonable opportunity to dispose of the property or the Nursing Director shall be notified, and the property shall be secured and removed to an outside storage facility with resident's permission until discharge.

h. LHH provides a locked resident bedside drawer. A key is provided to the resident and a second key is kept by the Nurse Manager or designee.

i. Subsequent items brought into or removed from the facility shall be added to or deleted from the IRP in electronic health record by a staff member. LHH shall not be liable for property that has not been included in the IRP or for property that has been deleted from the IRP. Personal property not subject to addition or deletion from the IRP because of frequent delivery and/or removal from LHH, such as personal clothing or laundry, need not be listed, and such status of those properties shall be noted on the IRP. Friends or relatives who are asked to take property home shall sign the printed IRP and the form shall be scanned into the electronic health record.

j. Nursing staff shall label or mark all resident's property listed on the IRP. Property shall be marked with an indelible ink pen, identifying the resident's name. Nursing staff shall be required to permanently label personal items (such as prosthetic devices and small appliances).

k. Resident dentures shall be engraved by dental services for identification purposes.

   i. Residents who have dentures shall have a referral made to the dental clinic for the dentures to be engraved for identification purposes.

   ii. Loss or damage of dentures shall be the responsibility of LHH and may not be charged to the resident for the loss or damage in accordance with LHH policy (LHHPP 24-27 Denture Replacement).

   iii. Residents shall be promptly referred by his or her physician, within 3-days, for dental services if dentures should be lost or damaged. If a referral should not occur within 3-days, nursing staff shall provide documentation of care plan adjustments to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

   iv. If necessary or requested, LHH staff shall assist the resident in making appointments and/or arranging transportation to and from the dental services location.

l. It is important that details of the resident's property be recorded. Examples: Record the color of various articles of clothing, brand names of radio, electric razor, watch, personal wheelchair or television set, and serial number of wheelchairs or television sets, when describing jewelry, document the color of the metal and stones i.e., "one yellow metal ring with clear glass stone. Do not guess at the nature of the metal, i.e., gold color metal vs. pure gold.

m. ~~Place resident's soiled personal clothing in the designated clothing hamper located in each household neighborhood.~~ Place resident's soiled clothes in resident's soiled linen hamper in the soiled utility room. Clean clothing is stored in the resident's individual space, such as a wardrobe locker/closet or bedside stand. If

the resident's clothing is damaged or unable to be adequately cleaned, or needs to be disposed, consult with the resident. If disposal of property is then agreed upon, document the disposal and the basis for doing and update the IRP in the electronic health record.

n. Staff must not accept or ask a resident to borrow personal items or money, nor should they attempt to gain access to a resident's holdings, money, or personal possessions through persuasion, coercion, request for a loan, or solicitation.

**2. Resident's Property on Relocation**

a. Nursing staff shall assist the resident in collecting his/her property before the resident relocates. The resident's bedside stand and locked drawer shall be checked for properties belonging to the resident. The IRP shall be updated to reflect any property that is no longer present or new property. Nursing staff shall review the IRP with the resident and the resident and nursing staff shall sign the printed form and scan into the electronic health record indicating that the property is relocating with the resident to the new neighborhood, with the date. The receiving neighborhood shall validate IRP and complete the section on relocation. If valuables are found that exceed a value of $50, the resident shall be reminded to store them in the secure area at the A&E office.

**3. Resident's Property on Transfer and Discharge and at Time of Death**

a. Nursing staff shall assist the resident with gathering the resident's property from the resident's bedside stand, locked drawer, and wardrobe.

b. The IRP in the electronic health record shall be updated to include property not previously listed and those that are not present with stated disposition of the property date and a signature.

c. The resident and nursing staff shall review the IRP and the resident / surrogate decision maker and staff shall sign off, signifying return of the property to the resident or his/her surrogate decision maker.

d. Valuables not taken by the resident upon discharge shall be listed by nursing staff on the IRP and the property shall be placed in an envelope labeled with the resident's name, unit, medical record number, contents and date of discharge and brought to the A&E office.

e. Any property not claimed by the resident on the date of discharge shall be placed in a paper bag, bag, or box and stored in the facility for up to 45 days. The Medical Social Worker (MSW) shall send a letter addressed to the resident or the resident's representative instructing them to retrieve the resident's property within thirty (30) days from the date of the letter. The letter shall also state that unclaimed property will be donated or otherwise discarded if not claimed within 30 days. A copy of the

letter shall be scanned to the Health Information Management (HIM) Department for filing in the resident's electronic health record.

f. If a resident is discharged, is not anticipated to return or cannot be contacted, and there is no known representatives or heirs, A&E personnel shall immediately provide written notice to the San Francisco Public Administrator as specified by Section 7600.5 of the CA Probate Code. A&E staff shall follow the San Francisco Health Code Section 127 and Civil Code Section 1862.5 in the disposition on of unclaimed personal property.

Note: If absent without leave (AWOL) or against medical advice (AMA),~~,~~ refer to LHHPP 20-01 Admission to LHH and Relocation between LHH SNF Units.

g. Within 30 days following the death of a patient/resident, except in a coroner or medical examiner case, all money and valuables of that patient/resident which have been entrusted to the licensee shall be surrendered to the person responsible for the patient/resident or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient/resident without known heirs dies, written notice within five working days, shall be given by the facility to the public administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be available in the facility for review by the Department.

## 4. Residents Returning from Out on Pass

a. When a resident returns from being Out on Pass, s/he shall be reminded by nursing staff to disclose new items brought into the hospital so that the IRP can be updated. If the resident refuses to have his/her property inventoried after all reasonable efforts have been made to enlist the resident's cooperation, the resident shall have a reasonable opportunity to dispose of the property or the property shall be inventoried by staff.

## 5. Reporting Stolen or Lost Property

a. Staff shall complete an Unusual Occurrence (UO) Report for missing, stolen or lost property.

i. For lost and stolen property, the neighborhood staff notified of the loss shall complete an online UO Report and include the following information: (1) a description of the article (2) its estimated value (3) the date and time the theft or loss was discovered (4) if determinable, the date and time the loss or theft occurred, and (5) the action(s) taken. Quality Management staff shall maintain a documented theft and loss record for the past 12 months. The record shall be made available to the State Department of Health Services, the county health department, or law enforcement agencies and to the office of the State Long-Term Care Ombudsman when requested.

b. When staff or resident has reason to believe that a resident property has been stolen, they shall report the loss immediately to the charge nurse or Nurse Manager (LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response). The Nurse Manager or Nursing Supervisor shall report immediately and no later than two (2) hours to:

   i. San Francisco Sheriff Office (SFSO)

   ii. California Department of Public Health (CDPH)

   iii. Quality Management Department

   iv. Chief Executive Officer or Administrator on Duty

c. Staff shall assist thea ~~resident or patient~~the resident/patient or complete a grievance form on their behalf for any lost or stolen property.

~~c.~~d. Resident theft and loss prevention monitoring shall be included in the LHH Quality Assurance Performance Improvement (QAPI) Plan.

## 6. Resident Notification

a. Upon the resident's admission, Social Services staff shall provide a resident guide which includes information relating to LHH's theft and loss prevention program.

b. A copy of LHH's theft and investigative procedures are posted in each neighborhood.

## 7. Claims and Liability

a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. The Medical Social Worker or any member of Resident Care Team (RCT) may assist resident in completing claims form.

~~a.~~b. The MSW~~Social Worker~~MSW or any member of the RCT~~Resident Care Team~~RCT shall ~~either~~ assist the resident/patient with or complete a grievance on their behalf ~~of residents or patients~~ that have a loss of property.

~~b.~~c. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other

actions or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

**ATTACHMENT:**
None.

**REFERENCE:**
LHHPP 20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 24-06 Resident/Patient Visitor Complaints and Grievances
LHHPP 22-12 Clinical Search Protocol
LHHPP 24-27 Denture Replacement
LHHPP 75-07 Theft and Lost Property
"Claim Against the City and County of San Francisco" City Attorney FORM2 (rev. 2/01), http://www.sfgov.org/site/cityattorney_index.asp?id=460

Revised: 06/04/03, 12/09/25, 15/07/14, 19/05/14, 19/07/09, 20/09/08, 21/02/08, 22/05/10 (Year/Month/Day)
Original adoption: 92/05/20

# PROMOTING/MAINTAINING RESIDENT DIGNITY

## POLICY:

It is the practice of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect and promote resident rights and treat each resident with respect and dignity. LHH cares for each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality.

## PROCEDURE:

1. All LHH staff members who are involved in providing care to residents shall promote and maintain resident dignity and respect resident rights.

2. During interactions with residents, staff shall report, document and act upon information regarding resident preferences.

3. Assessment and interview results shall be documented; the provision of care and care plans shall be revised, if appropriate, based on information obtained from any resident assessments and interviews.

4. The resident's lifestyle choices and personal preferences shall be considered when providing care and services to meet the resident's needs.

5. When LHH staff are interacting with a resident, the resident shall be treated as an unique individual.

6. LHH responds to each request for assistance by a resident in a timely manner.

7. All staff members shall explain care and/or procedures to the resident before initiating said procedures.

8. Staff members should not talk to each other while performing a task with and for the resident as if the resident is not present. All conversation during the provision of care should be resident focused and resident centered.

9. Residents shall be dressed and groomed according to their preferences.

10. All staff shall speak respectfully to residents and shall avoid discussions about residents that may be overheard.

11. LHH respects the resident's living space and personal possessions. At no time shall staff search a resident's body or personal possessions without consent from the resident, or if applicable, the resident's surrogate decision's maker (SDM). The resident or the SDM shall understand the search is voluntary and why the search is being conducted.

12. LHH shall maintain resident privacy in all areas where care may be provided. This includes but is not limited to a resident's room, the great room, or any area where the resident is agreeable to receive care. This shall be specified in the resident's care plan as their preference.

~~12.~~13. LHH supports patient privacy/dignity during medication administration by pulling curtains in room or closing room door prior to administering medications or confirming with the resident that they prefer to not have the curtain pulled and/or the door closed. The resident's care plan shall specify their preferences. ~~.~~

~~13.~~14. All LHH staff shall assist residents to participate in activities of their own choice.

~~14.~~15. Each resident shall be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.

**ATTACHMENT:**
NONE

**REFERENCE:**
NONE

Original adoption: 22/12/13 (Year/Month/Day)

# COACH USE FOR CLOSE OBSERVATION

## POLICY:

1. Nursing Services at Laguna Honda Hospital and Rehabilitation Center (LHH) is responsible for providing close observation of residents when needed. The nurse manager/charge nurse in collaboration with Nursing Operations staff are responsible for allocating staff for coach assignment to provide the appropriate level of supervision.

2. Resident behaviors that may require close observation include but are not limited to the following:

    a. High risk for falls

    b. Impulsive behavior

    c. Risk for aggression

    d. Elopement risk

    e. Intrusive behavior

    f. Harm to self or others (See Policy #3)

    g. Other extenuating needs as determined by Resident Care Team (RCT) and with the approval of Nursing Director/Nursing Operations

3. Long-term close observation measures are not intended for residents who are having suicidal ideation (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.

    a. For residents who are having active suicidal ideation and scored at medium risk, a temporary coach shall be provided while waiting for further psychiatric evaluation.

4. The need of a coach is a nursing decision and is intended as a short-term intervention while developing a long-term plan for resident safety.

5. The RCT is responsible for the initial assessment and ongoing evaluation/need for close observation measures.

6. Nurse Director/Supervisor shall approve all coach assignments based upon the RCT assessment.

7. Coaches shall provide continuous close observation of engage the resident as appropriate and provide all care needs within the scope of their licensure or certification while ~~avoiding any distractions~~refraining from the following ~~as follows~~:

   a. Speaking in a non-business language or a language the resident does not understand,

   b. Using personal cell phone,

   c. Reading,

   d. Sleeping on the job.

8. LHH Patient Care Assistant (PCA)/ Certified Nursing Assistant (CNA) are expected to contribute to the electronic health record (EHR) documentation each hour for a resident who is provided with a coach.

9. The team leader/charge nurse is responsible for checking the resident's condition frequently and as needed .

10. The Licensed Nurse (LN) shall review EHR coach documentation for their shift and determine if the coach status is initiated, continued, or discontinued.

**PURPOSE:**

To provide a therapeutic and physically safe environment with appropriate level of supervision for residents who have been determined to have safety needs that exceed routine care and intervention measures.

**PROCEDURE:**

1. **Role of the RCT**

   a. If the RCT determines that a resident's behaviors and condition require close observation, the RCT shall do the following:

      i. Assess the need

         - The RCT (at a minimum, the MD and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.

      ii. Develop an observation and intervention plan as follows:

         - Possible close observation measures may include, but are not limited to:

- Increasing/decreasing the frequency of observation time periods
- Assignment of staff to provide close observation/cohort residents needing close observation
- Develop measurable goal/s related to the use of close observation. ~~iii.~~
- Implement the plan
- The nurse manager/charge nurse shall assign staff as permitted, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse/team leader shall round frequently to check on the resident's condition and for updates.
- Any request for additional staff used as coach shall be made through the Nursing Office.
- When a resident's family member or significant other assists with the resident's care and observation, the care plan shall reflect their participation and education. Nursing staff shall maintain overall responsibility for the care provided to the resident, including appropriate education on safety measures to be given to the resident, family and/or staff providing close observation of the resident.

iii. Evaluate the plan ~~(Focused Review)~~

- While close observation is implemented, the RCT shall meet regularly and at least quarterly to:
- Review any changes in resident's condition.
- Assess effectiveness of current interventions.
- Evaluate resident goals and the need for ongoing close observation.
- The RCT shall summarize each meeting via EHR.
- The RCT and other consultants may conduct a Focused Review
- If no progress is made, resident case may be referred to clinical leadership for long term placement.

2. **Role/Expectations of the Coach Providing Close Observation**

a. A coach should be made aware of three important aspects of their assignment:

i. Why they are assigned to the resident.

ii. What goals are identified for this resident.

iii. What interventions can be employed with the resident.

b. The coach may provide close observation for one or more residents (cohort). All coach staff that are LHH employees–are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:

i. Reporting to the charge nurse at the start/end of their shift for endorsements and obtaining shift endorsement from outgoing coach.

ii. Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.

iii. Engaging the resident with goal-focused resident-centered interventions and ongoing activities.

iv. Observing, reporting and documenting resident behavior, including observation antecedents the agitate or improve resident behavior.

~~iv.~~v. Providing nursing care as within their scope, which may include feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and pivot transfers as ordered.

~~v.~~vi. Ensuring environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.

~~vi.~~vii. Contributing to the RCT discussions and/or plan of care.

~~vii.~~viii. Transporting/escorting residents ~~—to ——internal/external ——scheduled appointments.

~~viii.~~ix. Other duties as assigned, including specific responses to certain needs of the resident.

c. Coaches shall not leave residents unattended under any circumstances and are to use call light to summon for help/breaks/etc.

d. Registry coaches shall perform all the duties as outlined above. Registry coaches may assist the LHH nursing assistant or licensed nurse but may not perform the following tasks independently:

i. Feeding residents on a Specialized Feeding Plan ii. Showering/bathing

iii. Use of any equipment or assistive devices for which they have not been trained.

3. **Documentation** (See Attachment A for table reference)

a. The coach providing the close observation shall identify and report physical changes such as alterations in gait -that may increase risk of falls, changes in urination and bowel patterns, changes in skin, level of weakness,- and vital signs. They shall also report any observable non-physical changes in demeanor, appetite, sleep patterns, increased confusion or agitation,- and reports of pain and document their observations, as well as any potential antecedents and interventions via the EHR.

~~document their observations of the resident's behavior and any interventions each shift via EHR.~~

~~a.~~ LHH PCA/CNA who are assigned as coaches are expected to complete EHR documentation.

b. ~~Observations documented via EHR shall be incorporated in the LHH Nursing Weekly Summary by the licensed nurse.~~

c. The behavior monitoring flowsheet shall be completed ~~every shift~~regularly by nursing and other clinical staff as appropriate. LHH Nursing Weekly Summary shall be completed by the LN via ~~EHR~~EHR to include any changes reported by coaches.

d. The care plan shall be updated by LN on an ongoing basis and include any new interventions for addressing the safety needs of the resident, including the ongoing need for close observation as an intervention.

e. Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.

f. Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

**ATTACHMENT:**
Attachment A: Coach Use for Close Observation Roles and Responsibilities

**REFERENCE:**
None.

Revised: 21/07/29,00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10, 21/10/12, 22/12/13, 23/06/13 (Year/Month/Day)
Original adoption: 98/11/16

**Attachment A: Coach Use for Close Observation**
**Roles and Responsibilities**

| Role | Responsibility |
|---|---|
| **LHH PCA/CNA** | • Responsible for all duties within their scope of practice for assigned resident.<br>• Documents via EHR and communicates resident behaviors to regular CNA and or team.<br>• Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet |
| **Registry Coach** | • May assist LHH nursing assistant or licensed nurse but not use any equipment or assistive devices for which they have not been trained |
| **Regular CNA** | • Completes EHR documentation with input from Coach<br>• Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet |
| **Charge Nurse/ Licensed Nurses** | • Assigns coach based upon available nursing staff.<br>• Gives report to oncoming coach<br>• Completes rounds frequently for updates<br>• Documents any behaviors in EHR behavior monitoring flowsheet |

| | |
|---|---|
| | • LN will review EHR coach documentation for their shift and determine was the coach status initiated, continued or discontinued. |
| **Resident Care Team** | • Assesses need for Close Observation<br>• Conducts focused review to evaluate continued coach need<br>• May provide focused review with consultants<br>• May refer to Clinical Leadership for placement |

# RESIDENT LOCATOR SYSTEM

## POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) Resident Care Teams (RCT) may use a tracking system (also called locator system) to reduce risk of loss, injury, and other adverse outcomes for residents.

## PURPOSE:

LHH's goal is to provide care in the least restrictive setting. The use of the resident locator system is intended to ensure safety and maximize resident's freedom.

## BACKGROUND:

LHH has installed in its new building a Wi-Fi based tracking system (brand named AeroScout®). A tag worn by a resident regularly signals its presence. Standard Wi-Fi access points detect the signal, which system software uses to determine the tag's location and to associate it with the resident's name, MR#, and primary language. Special detectors, called exciters, are installed in critical locations (including exits from the LHH neighborhoods, fire doors, main hospital exits, entrance to swimming pool). These cause a nearby tag to signal its presence. For any resident wearing a tag, the authorized area for wandering is determined and pre-programmed. If the resident attempts to go into an unauthorized location (e.g., an elopement risk resident exits a fire door), the system transmits alerts to predetermined recipients via their wireless devices, so that staff can intervene.

## PROCEDURE:

### 1. Resident Assessment:

a. At every assessment (admission, re-admission, quarterly, annual, significant change of condition, or other as needed), the RCT will assess each resident for wandering/elopement risk.

b. If the RCT determines the resident is cognitively impaired and has a prior history of, or a new episode of, wandering, elopement, or inability to return to the neighborhood without help, the RCT will discuss the risks and benefits of monitoring the resident with the locator system.

c. If deciding to use the locator system, the RCT will identify the resident's risk category as one of the following:

i. Not safe to leave the neighborhood unescorted (resident category is "Unauthorized").

ii. Safe to walk unescorted through LHH's new building (resident category is "Indoor Only").

d. The RCT will discuss the plan and describe the nature and purpose of tracking with the resident and/or surrogate decision maker. The physician then obtains Informed Consent from the resident and/or the surrogate decision maker.

e. The physician will order in EHR for both the application of the locator tag and the category of AeroScout authorization (i.e., "Unauthorized" or "Indoor Only").

f. If the resident's condition improves and the AeroScout tag is discontinued based on the RCT's determination, the resident and the decision maker will be notified. The notification will be documented in EHR.

g. If an AeroScout tag is needed to be reapplied based on the RCT's determination, a new consent will be obtained. This also applies to a readmission after a 7-day bed hold has been loss.

**2. Placement of the Resident Locator Tag:**

a. The resident's care plan shall include location tracking, the Charge Nurse or designee shall:

i. Use the system database to assign a tag; place the tag on the resident (usually with a wristband; other options might include attaching to a wheelchair); and set the resident's tag to the appropriate risk category (i.e., "Unauthorized" or "Indoor Only").

ii. Check that the database correctly associates the tag to the resident's full name, Medical Record Number (MRN), date of birth, gender, primary language, and photograph.

iii. Test that the locator tag appears on the monitoring map.

**3. Resident Locator System and Communication of Alerts:**

a. Location Monitoring: From a nursing station computer, the neighborhood staff can locate the resident's tag on maps of the neighborhoods and inside the hospital building.

b. When a Stage 1 Alert is triggered, an audible alert (i.e., "Stop, go back") is heard through the speakers above the first set of exit doors on the neighborhood.

c. When a Stage 2, 3, or 4 alert is triggered, designated AeroScout® computers at the nursing station will display a pop-up message with the resident's name, photograph, and current location on a facility map. Neighborhood staff will also receive alerts on their wireless devices containing the resident's name and location.

d. North and South Residence Neighborhood Alerts:

i. A Stage 1 Alert (Redirection) is triggered if an "Unauthorized" resident approaches the exciters above the neighborhood's first main exit door. The audible alert is a pre-recorded message that states, "Stop, go back.". (Messages are available in several languages).

ii. A Stage 2 Alert is triggered if an "Unauthorized" resident does not respond to the Stage 1 Alert and continues to the door adjacent to the elevators. The resident's name and location is sent to neighborhood staff's wireless devices

iii. Pavilion Mezzanine and Pavilion Acute Neighborhood Alerts:

- Due to architectural reasons, the Pavilion Mezzanine and Pavilion Acute neighborhoods will only use Stage 3 and Stage 4 elopement alerts. Staff on these neighborhoods will be trained to monitor the elevator area for elopement risk residents that attempt to leave the neighborhood.

iv. A Stage 3 Alert is triggered for the following:

- If an "Unauthorized" or "Indoor Only" resident exits via a delayed egress fire door. The resident's name and location is sent to the neighborhood staffs wireless devices.

- If an "Unauthorized" resident approaches or enters an elevator. The resident's name and location is sent to neighborhood staffs wireless devices and the resident's tag status is automatically updated to "Wandering".

v. A Stage 4 Alert is triggered if a resident with an "Unauthorized" or "Indoor Only" tag exits the Pavilion main doors, a loading dock door, a ground floor exterior fire exit door, or enters the pool area. The resident's name and last known location is sent to the neighborhood staff's wireless devices. A pop-up notification will also appear on the neighborhood's designated AeroScout® computers as well as the Sheriff's designated Aeroscout computer. The resident's tag status is automatically updated to "Wandering Outdoors".

vi. Staff should verify the resident's last point of exit within the hospital to

determine the resident's last known location as the icon on the hospital map will be seen bouncing around while it is attempting to find the tag it's associated with.

**4. Authorized Exits:**

a. For All Neighborhoods:

i. Appointments and Activities within LHH: The neighborhood staff can temporarily change a resident's tag status from "Unauthorized" to "Indoor Authorization" via MobileView software. The resident can then be escorted off the neighborhood without triggering an alert.

ii. Appointments and Activities outside of LHH: If a resident needs to be escorted off campus (e.g. SFGH appointment) without triggering an alert, neighborhood staff can change a resident's tag status via MobileView software to "Full Authorization".

iii. For the North and South resident neighborhoods, the resident's AeroScout tag will automatically reset to the resident's original status upon re-entry to the unit. Once the resident has returned to the unit, staff is responsible for verifying that the resident is present and that the resident's tag status has been updated correctly. For Pavilion Residence Neighborhoods, the neighborhood staff must manually reset the resident's tag to the original status using MobileView.

**5. Responding to Resident Locator System Alerts:**

a. Neighborhood staff is responsible for responding to resident locator system alerts by locating and redirecting the resident safely back to the neighborhood.

b. If the resident cannot be located, staff will initiate post-elopement response procedures. (See Elopement Response Procedure.)

**6. Checking Resident Locator Tag and Function:**

a. The neighborhood Charge Nurse or designee is responsible for maintaining the database of neighborhood residents who wear locator tags, and for communicating to neighborhood staff which residents wear the tags.

b. The neighborhood Charge Nurse or designee is responsible for the following:

i. Upon admission, readmission, or relocation of a resident assigned an AeroScout® tag, the Charge nurse/designee will assign and/or check that the resident has the appropriate category of authorization on the MobileView as per physician order.

ii. The Charge Nurse or designee will verify that when a resident with an assigned tag returns to his/her neighborhood (e.g. from OOP, outside appointments, ER visits, LHH clinic or rehab appointments), the resident is still wearing the assigned tag. The Charge Nurse/ designee will also confirm through MobileView that the resident's name, MRN number, category, and status are accurate and have reverted back to the original form.

iii. Every shift, the Charge Nurse/designee will:

- Ensure that each nursing assistant verifies the placement of a resident's AeroScout tag and documents this information in the electronic health record (EHR).

- Print an AeroScout assets list report and check that each resident with an assigned tag has an associated tag ID, has the correct MRN associated with the resident, has the correct Category and Status, resident is detected in the neighborhood, or the resident's location is otherwise known (e.g., out on pass), and the last update time is current.

iv. Upon discharge of a resident with an AeroScout tag to home or community, the Charge Nurse or designee will remove the AeroScout tag from the resident.

c. The neighborhood Charge Nurse or designee is responsible for checking at each shift the tag's battery status using the AeroScout® battery level report.

i. If battery level is below 20%", the Charge Nurse or designee immediately issues a new tag to the resident and places the low-battery tag in a bin to return for battery replacement.

d. The assigned caregiver checks the resident's tag and strap for wear and tear at each shift.

**7. Staff Education:**

a. Neighborhood staff shall be trained upon orientation or if transferred within LHH on the use of the resident locator system and response to its alerts.

b. Additional education shall be provided to staff if a significant system enhancement is implemented or whenever indicated.

c. Neighborhood staff will be trained that residents with elopement/wander risk must be always escorted by staff while in the garden areas (detectors do not currently cover the garden areas).

d. All staff are to be educated to be cautious when entering or exiting controlled areas to prevent accidental resident elopement.

**8. Performance Improvement:**

a. The Licensed Nurse shall complete an Unusual Occurrence report if a resident elopes from the neighborhood.

b. Resident elopement incidents will be periodically reviewed to identify process improvement opportunities and staff training needs.

**9. Other Uses:**

a. If the Resident Care Team (RCT) identifies possible uses for the locator system that would enhance the resident's safety and quality of life, these possibilities may be discussed with the resident and/or surrogate decision-maker for approval. The use of the resident locator system shall be described in the resident's care plan.

**ATTACHMENT:**
None.

**REFERENCE:**
AeroScout® Operation Manual
Nursing System Manual (LagunaNet: Nursing)
LHHPP 24-01 Missing Resident Procedures
LHHPP 24-04 Resident Found Off Grounds
LHHPP 60-04 Unusual Occurrences

Revised: 11/07/26; 12/03/27, 16/07/12, 19/07/09, 23/01/10 (Year/Month/Day)
Original adoption: 10/12/03

# 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.

    d. Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications and herbal supplements, require a physician's order which includes:

    a. Medication name/agent

    b. Dose

    c. Frequency

    d. Route of administration

    e. Indication for use.

        i. 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. 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.

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.

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.

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.

15. Medications may not be added to any food or liquid for the purpose of disguising the medication, except in the following limited circumstances:

a. a resident who has capacity to make their own health care decisions and provides written consent; or

b. a resident who is LPS-conserved and has a current, valid court order that determines the resident does not have the right to refuse the type of medication in question (i.e., “Affidavit B” for psychiatric medications); or

c. a resident who is conserved under the Probate Code and has a current, valid court order that explicitly grants the conservator authority to consent to health care, whether or not the conservatee objects, and the conservator consents in writing; or

d. a resident who has been found by a court or their physician to lack capacity to make their own health care decisions and has in place a current, valid, signed durable power of attorney or advanced directive form which explicitly authorizes the legal decisionmaker to consent to all medications or the type of medication in question and the decisionmaker consents in writing.

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. Controlled substances shall be disposed of in the RxDestroyer located in the medication rooms. All other medication is disposed of in the yellow and white pharmaceutical waste bin.

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.

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.

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

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

21. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications for oral administration (medications may not be combined for enteral tube administration as noted above), and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

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

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.

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

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”.

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.

27. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone if ordered.

28. Residents who request to self-administer medications and/or herbal supplements must be assessed by Resident Care Team (RCT) and determined to be able to safely self-administer medications.

29. Herbal supplements are not medications. The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary. Non-formulary herbal supplements are limited to USP verified supplements.

30. All medications and herbal supplements for self-administration will be stored securely by nursing, including rescue medications, except nasal naloxone. Rescue medications, such as inhalers will be given to resident when they go out on pass with physician order and will return medication for safe storage on their return, with the exception of nasal naloxone that resident can safely store on person or at bedside.

**DEFINITIONS:**

- BCMA: Bar Code Medication Administration
- eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record

- EHR: Electronic Health Record
- WOW: Workstation on Wheels

**PURPOSE:**

Medications will be competently and safely administered.

## A. CRITICAL POINTS

### 1. Six Rights of Medication Administration

. Right Resident

i. Two forms of identification are mandatory.

ii. Verify identity of resident using any of the following two methods:

iii. 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)

iv. Resident is able to state his/her first and last name (Ask for first and last name without prompting)

v. Resident Medication Profile Photograph matches the resident image in the EHR.

vi. Resident is able to state date of birth (Ask without prompting.)

vii. In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.

viii. 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

a. Review eMAR for drug/medication ordered

b. Review resident allergies to medications or any other contraindication

c. Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

i. Checks or verifies information about medication using one or more of the following references, when needed:

i. Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

ii. Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

**3. Right Dose**

a. Review eMAR for dose of drug/medication ordered

b. Check medication label and confirm accuracy of dose with eMAR

**4. Right Time**

a. Review eMAR for medication administration time.

i. 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.

ii. All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.

iii. See Appendix I for routine medication times and abbreviations.

iv. Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix AI~~I~~.

**5. Right Route**

a. Review routes of administration

i. Aerosol/Nebulizer: Refer to NPP J 1.3

ii. Enteral Tube Drug Administration: Refer to NPP E 5.0

iii. Eye/Ear/Nose Instillations: Refer to J 1.4

b. 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: Laguna Honda Hospital IV Push Guidelines

**6. Right Documentation**

a. Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.

b. If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.

c. 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:

2. Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time.

3. 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 with “do not crush” in the admin instructions of the eMAR.

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:

. 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.

a. 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.)

b. If using pudding as the food medium to administer medications, a physician order is required for the pudding.

c. 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.

**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.

    . 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.

    a. 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.

    b. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.

    c. 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.

d. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.

e. Repeat this for each resident that need medication(s) removed if needed.

f. 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.

. Support patient privacy/dignity by pulling curtain in room or closing room door prior to administering medications, or confirm with resident that they prefer to not have the curtain pulled and/or the door closed and has care plan specifying this preference~~.~~

**a.** If administering medication(s) in community or common area, such as the great room, confirm with resident they would like to receive medications in that area and resident has care plan specifying preference/acceptance of receiving medications in the ~~community~~common area.

~~4.~~5. Scan the arm band of resident to correctly identify resident and open their MAR.

. 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.

a. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.

b. 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.

~~5.~~6. Scan medication(s) barcode(s) at bedside/chairside.

~~6.~~7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

~~7.~~8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).

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

~~8.~~9. Remain with the resident until all medications have been taken.

. Never leave medications at the bedside/chairside.

~~9.~~10. Document in real time in the EHR medication(s) given, not given, etc.

~~10.~~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.

. 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).

a. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.

b. 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. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, confirmation of swallowing is required after administering medication:

    . 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.

    a. If resident declines to allow confirmation, notify the resident the narcotic medication will be held and notify provider for further guidance.

        i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.

        ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.

        iii. Notify resident care team of refusal for discussion of alternatives and interventions.

        iv. Document occurrence in a nursing note and update care plan.

2. Administration of buprenorphine-naloxone.

    . 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.

    a. Buprenorphine administration is as follows:

        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.

            - 5-10 minutes for sublingual tablet

            - 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.

b. 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)

. Use with nebulizer face mask, which has medication cup and lid.

a. 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.

b. 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 (CO2) 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.

c. 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 later if medication is still unopened and in the original packaging.

2. If medication(s) is not given within the time schedule, review “Appendix BII: 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 workspace 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 evenly distribute the dose, 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.

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. Fentanyl patch disposal requires a two LN independent check of medication disposal and will be documented in Omnicell.

    b. After removing the patch, fold the old patch in half so that the adhesive sides are in contact, request 2nd license nurse to witness the disposal in medication room disposal container and both LN's will complete documentation of the waste in Omnicell.

**SELF-ADMINISTRATION**

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. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be 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 medication this will be communicated to the physician and to the resident.

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.

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 prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-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, the nurse will intervene to stop the preparation. The nurse 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 herbal supplements via self-administration will document 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

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

k. The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications

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

**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 either the blue and white pharmaceutical waste bin or the yellow 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. 2nd LN 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.

**EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX**

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.

    i. The nurse will have the order filled at the hospital Pharmacy.

    ii. The pharmacist will dispense the medications in properly labeled child-proof containers.

    iii. 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.

    i. 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.

    ii. 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.

    iii. 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.

2. Personal medications will not be obtained, stored or used by residents.

3. 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, document on the MAR the med is not available, and actions taken to secure a supply.

2. Notify pharmacy via MAR message of need for dose

3. Administer when dose is available

4. If dose is grossly overdue, confer with physician and/or pharmacy on administering vs waiting till next dose is due

5. If not administered on shift it is due, a brief note should be entered in EHR indicating plan and follow up

## EXCESS MEDICATIONS

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

## ATTACHMENT:

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)

## REFERENCE:

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 Risk – High Alert Medications
LHHPP File: 25-02 Safe Medication Orders

LHHPP File: 25-03 Verbal/Telephone Orders
LHHPP File: 25-04 Adverse Drug Reaction Reporting 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 Incompatibility
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines
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
Nursing P&P *** Herbal Supplements: Formulary and Non-Formulary

Original adoption (as NPP J 1.0) : 23/06/13
~~(Year/Month/Day)~~
Hospital Wide Adoption: 2023/13/06 as 25-15 Medication Administration
Revised: (Year/Month/Day)

# TRACHEOSTOMY SPEAKING VALVE: INTERDISCIPLINARY PROTOCOL FOR USE OF THE PASSY MUIR VALVE

## POLICY:

1. When indicated, patients admitted to Laguna Honda Hospital and Rehabilitation Center (LHH) with tracheostomies shall be evaluated by Respiratory Therapy and Speech Pathology for a speaking valve upon physician referral.

2. Patients admitted to LHH already using a Passy-Muir tracheostomy speaking valve (PMV) or other tracheostomy speaking valve must be screened within 72 hours by Speech Pathology (SP) and Respiratory Therapy (RT) to determine need for further evaluation or intervention.

3. LHH shall provide colored (non-white) Passy-Muir speaking valves. If a patient is unable to tolerate a Passy-Muir valve, a different type of valve may be used.

## PURPOSE:

The Passy Muir Valve (PMV) is a one-way valve (i.e., open during inspiration, closed during expiration) that, when attached to the hub of a tracheostomy tube, allows for normal vocalization with louder volume and improved clarity; it also may assist with swallowing and secretion management. It is more hygienic than finger occlusion.

## PROCEDURE:

### 1. Criteria for Initial Evaluation With the Passy Muir Valve (PMV):

a. Medically stable patient.

b. More than 48 hours have lapsed after tracheostomy placement.

c. Cuffless tracheostomy tube, or able to tolerate cuff deflated.

d. Without excessive secretions.

e. Alert and attempting to communicate.

f. Able to tolerate sitting in a chair or in an upright position in bed.

g. If above criteria have been met, the physician shall order a Passy Muir Valve evaluation by both Speech Pathology and Respiration Therapy.

### 2. Initial Evaluation With PMV:

a. RT procedures

i. Suction patient's tracheostomy tube to remove any upper-airway secretions.

ii. Fully deflate cuff, if present.

iii. Suction airway again for any residual secretions.

b. Respiratory (RT) and Speech Therapy procedures:

i. Evaluate patient for ability to breathe comfortably with cuff deflated, monitoring respiratory rate, heart rate and oxygen saturation.

ii. Attempt to elicit phonation with finger occlusion of tracheostomy.

iii. If patient can phonate with finger occlusion, place PMV securely on tracheostomy tube. The PMV attaches to the 15mm hub of the tube. A plastic 15mm adapter is required for metal tracheostomy tubes.

iv. Assess patient's oxygen saturation level, respiratory rate and heart rate during a five-minute period with the PMV in place.

v. If patient demonstrates ability to tolerate the PMV, attempt to elicit phonation with PMV in place.

vi. If difficulties with breathing and/or voicing occur, ENT consultation may be indicated to reassess the tracheostomy, tube size/type and possible airway obstruction or vocal cord pathology/dysfunction.

**3. Procedures for Treatment/Monitoring of a Patient With PMV:**

a. If patient demonstrates ability to tolerate the initial PMV eval, SP shall continue to see patient for individual sessions as indicated, increasing tolerance and duration of PMV use.

b. SP may request assistance from RT or Nursing as needed.

c. Nursing staff and patient (if capable) shall be trained regarding PMV placement, removal, and precautions.

~~c.~~d. For residents receiving greater than or equal to 40% FI02:

~~For residents receiving greater than or equal to 40% FI02:~~

~~If titration is initiated, oxygen levels should be assessed with the PMV in place.~~

i. If titration is initiated, oxygen levels should be assessed with the PMV in place.

ii. If patient has a cuffless tracheostomy tube, nursing may place the PMV as instructed by the SP following these procedures:

iii. Suction patient's cuffless tracheostomy tube as needed or as per physician order.

iv. Ask patient to talk to ensure airway is unobstructed.

v. Monitor patient for signs of increased work of breathing or other signs of distress. Remove PMV immediately in the event of respiratory distress.

vi. Do not leave valve on if patient is sleeping.

vii. The degree of supervision required for ongoing PMV use is determined on an individual basis by the physician, SP, RT and Nursing, and documented in the treatment plan. Patient's cognitive and physical ability to recognize signs of distress and promptly remove valve must be considered.

~~d.~~e. If patient has a cuffed tracheostomy tube, PMV should be placed only by SP or RT.

i. Ensure that the sticker that warns staff to deflate cuff prior to placing valve is on the pilot balloon; Central Processing Department shall keep a supply of extra stickers.

ii. Place a sign at bedside stating the following: "If patient has cuffed tracheostomy, FULLY DEFLATE CUFF PRIOR TO PLACING Passy Muir Valve; do not leave valve on when patient is sleeping.

~~e.~~f. When suggested by SP, other therapists may be trained in valve usage and precautions; patient may then wear the PMV during sessions with those therapists, who shall monitor patient for any signs of distress.

~~f.~~g. Family members may be trained by Nursing or SP to monitor the patient's usage of the PMV and to monitor for signs of distress.

4. **Documentation**:

a. Evaluation and treatment shall be documented in the electronic health record.

**5. Care of the PMTSV:**

a. SP shall assume responsibility for care, cleaning, and storage of the PMV when patient is wearing it during SP sessions only.

b. Nursing shall assume responsibility for care, cleaning, and storage of the valve when the patient begins wearing it on the care Unit.

c. The following procedures shall be used:

i. Clean daily using soapy water; do not use hot water as it damages the PMV.

ii. Rinse and soak valve in a germicide solution per manufacturer's instructions.

iii. Rinse thoroughly with cool to tepid water.

iv. Do not use peroxide, bleach, or alcohol to clean the valve.

v. Do not brush valve.

vi. Do not autoclave or radiation sterilize.

vii. Do not use for more than one patient; the PMV is for single-patient use only.

viii. Replace PMV if it becomes noisy, vibrates, or shows any sign of damage. The valve is guaranteed for two months but should last longer if properly cleaned and maintained.

**REFERENCES:**

LHHPP 60-08 Risk Management Program
LHHPP 27-05 Tracheostomy Management
LHNP I3.0 Tracheostomy Care
Passy-Muir Valve Evaluation Form (MR 527) October 2, 2008
Passy-Muir Tracheostomy and Ventilator Speaking Valves Patient Education Handbook

Revised: 08/08/25, 09/01/13, 19/05/14, 22/07/12 (Year/Month/Day)
Original adoption: 01/07/26

# TRACHEOSTOMY MANAGEMENT/LARYNGECTOMY CARE ~~(consider two different P&P – one for tracheostomy and one for laryngectomy)~~

## POLICY:

Tracheostomy/Laryngectomy care/management shall be carried out by physicians and nurses on the neighborhood. Ear, Nose and Throat specialists (ENTs), ~~speech language pathologists~~ Speech Language Pathologists (SLPs) and Respiratory Therapist ~~respiratory therapists~~ (RTs) are available by consultation to provide assistance with laryngectomy and /or tracheostomy management.

## PURPOSE:

1. To ensure safety, continuity and standardization of care to Laguna Honda residents with laryngectomy and/or tracheostomies.

2. To provide a venue for collaboration among disciplines of nurses, physicians, respiratory therapists, and speech pathologists to facilitate resident care.

3. To educate hospital staff, residents, and their families regarding tracheostomy care.

## DEFINITIONS:

1. Tracheostomy Tube is placed into a stoma in the trachea to keep it open for breathing. The term for the surgical procedure to create this opening is tracheotomy.

2. A Laryngectomy Tube is placed into the stoma when a portion or entire voice box (larynx) is removed due to disease or trauma. This is to assure airway patency.

## REFERRALS TO SPECIALISTS

The resident care team (RCT) has resources available for assistance with tracheostomy and laryngectomy management. Electronic referrals to ENT, SLP or RT may be made for evaluation and treatment recommendations.

1. ENT referrals must be generated for the following conditions (see sections 3.a., 4.c. and 6.a.):

    i. Initial tracheostomy tube changes

    ii. Known complicated cuffed or uncuffed tracheostomy tube changes

    iii. Non-standard tracheostomy tube changes

b. If referral to RT is considered urgent, the charge nurse or attending physician shall contact RT via pager, in addition to generating an electronic referral.

c. If an ENT specialist is not available at LHH Clinic, then a referral to ENT at ZSFG shall be submitted.

**Laryngectomy Care**

1. ~~Laryngectiomy~~Laryngectomy type shall be documented in the medical record.

2. Routine~~g~~ laryngectomy care per nursing policy shall be ordered unless otherwise indicated. Routine~~g~~ laryngectomy care shall be rendered per nursing policy XXX Laryngectomy Tube Care.

3. Oxygen flow and/or mist interface will be ordered by the physician.

4. The attending physician may refer residents to Respiratory Therapy as~~in~~ indicated.

5. An extra ~~LaryTube~~ laryngectomy tube of the same size and type shall be available at the bedside.

~~1.~~

**Tracheostomy Care**

1. Tracheostomy type shall be documented in the medical record.

2. Routine tracheostomy care per nursing protocol shall be ordered unless otherwise indicated. Routine tracheostomy care shall be rendered per nursing protocol (NPP I 3.0 Tracheostomy Care).

3. When indicated, oxygen flow and mist interface will be ordered by the attending physician.

4. The attending physician may refer residents to Respiratory Therapy, if indicated.

5. An extra tracheostomy tube of the same size and type (e.g. cuffless or cuffed) shall be available at bedside.

**Passy Muir Valve (PMV)** ~~**Speaking Valves (e.g. Passy Muir valve)**~~

1. Residents admitted with a PMV ~~speaking valve (e.g., Passy Muir valve [PMV])~~ shall be referred to SLP and RT as per LHHPP 27-01 ~~Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir.~~ Passy Muire Valve: Interdisciplinary Protocol for Use of the Passy Muire Valve (PMV)

~~2.~~ The referral should be generated at or shortly after admission to allow the screening evaluation to take place within 72 hours of admission. ~~This needs to be aligned with updates on Rehab Referral P&P~~

~~2.~~

a. ~~The results of the screening evaluation shall be documented in the Speech Pathology section of the electronic medical record. This is spelled out in LHHPP 27-01 that is referenced in 3a~~

a.

**Cuffless Tracheostomy Tubes**

1. For the initial change of a cuffless tracheostomy tube, the attending physician shall submit an electronic referral to the ENT. For an urgent appointment, following submission of the referral, the Medical Clinic shall be contacted for appointment availability. If an ENT specialist is not available at LHH Clinic, then a referral to ENT at ZSFGH shall be submitted. (Note: If an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy.)

2. If no problems occur with the initial tracheostomy change, trained licensed nurses may carry out subsequent replacements of the tracheostomy tube. The cuffless tracheostomy tube shall be replaced monthly, or as directed per physician order. Unless otherwise indicated, all tracheostomy tubes shall be changed with the same tube type and size.

3. The ENT may make recommendations regarding tracheostomy management (e.g., downsizing, changing from cuffed to cuffless, etc.).

4. Known complicated cuffless tracheostomy tube changes shall be performed by ENT.

**Cuffed Tracheostomy Tubes**

1. The attending physician shall document in the medical record if a patient is admitted with a cuffed tracheotomy tube and shall document specific orders regarding cuff inflation/deflation.

2. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedures/precautions.

3. For the initial change of a cuffed tracheostomy tube, the attending physician shall submit an electronic referral to the ENT. For an urgent appointment, following submission of the referral, the Medical Clinic shall be contacted for appointment availability. If an ENT specialist is not available at LHH clinic, then a referral to ENT at ZSFGH shall be submitted. (Note: If an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy.)

4. All subsequent cuffed tracheostomy tube changes shall be performed by Respiratory Therapy. The cuffed tracheostomy tube shall be replaced monthly, or as directed per physician order. Unless otherwise indicated, all tracheostomy tubes should be changed with the same tube type and size.

5. Known complicated cuffed tracheostomy tube changes shall be performed by the ENT.

**Tracheostomy and Laryngectomy Follow-up**

At the request of the RCT, referrals to ENT, SLP and/or RT may be made to:

1. Assist the RCT to establish and meet goals for each resident (e.g., downsizing tracheostomy, changing from cuffed to cuffless tracheostomies, decannulation, etc.).

2. Determine a monitoring and/or re-evaluation schedule for each resident, on a case-by-case basis.

3. Provide education and training to the staff relating to the use and purpose of tracheostomy equipment.

4. Provide education and training to the resident and family, if needed.

**Non-standard Tracheostomy Tubes (e.g., extra-long tracheostomy tubes):**

1. If a resident is admitted with a non-standard tracheostomy tube, the resident shall be referred to ENT for evaluation and the initial tracheostomy change. The ENT/RCT shall determine which discipline will manage subsequent changes.

~~**PROCEDURE:**~~

~~**Care and Cleaning of the Laryngectomy Tube**~~

~~1. A laryngectomy tube has 3 parts, outer tube or cannula, inner tube or cannula and obturator. There are also laryngectomy plastic/rubber tubes that can also be used. This tube is used to keep the airway patent.~~

~~2. A spare laryngectomy tube that is being used for the resident should be kept at bedside for emergent replacement in the event the tube is dislodged.~~

~~**Cleaning and Care:**~~

~~a. Obtain equipment and items needed for cleaning procedure. This should include a Tracheostomy cleaning kit, Tube Tie, gauge etc. Explain procedure to patient/resident.~~

~~b. Remove the Laryngectomy tube to be cleaned. Inspect the area around the stoma and wall of the trachea for mucus or crusts of secretions that might have formed between cleanings.~~

~~c. Using gauze dampened in saline to clean the stoma area and dry.~~

~~d. Clean the tube using the brush provided in the tracheostomy cleaning kit. Clean each part of the tube if it is that design. Use saline for cleansing and rinsing. Shake off any extra water/saline. Insert the obturator, if applicable.~~

~~e. Lubricate the tip of the tube with water-soluble jelly. Insert the tube into the Stoma. Do not tilt the head back as this may narrow the stoma.~~

~~f.. Support the tube, right away and secure the tube with a Tie.~~

**Emergency Resuscitation/Ventilation:**

a. In the event of a Cardiopulmonary or Respiratory Arrest, initiate a Code Blue. Ventilation can be performed by using a BVM delivering breaths per Code BLS protocol. Responding Physician's or RCP's can insert a Cuffed Trach Tube, inflate the cuff and provide ventilation by this means.

**ATTACHMENT:**
None.

**REFERENCE:**
LHHPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the ~~Passy-Muir~~
Passy Muir
NPP I 3.0 Tracheostomy Care

Revised: 09/09/30, 10/04/27, 18/09/11, 19/05/14, 22/07/12 (Year/Month/Day)
Original adoption: 08/11/25

# EARTHQUAKE REPONSE PLAN

## POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents even while responder to natural disasters such as earthquakes and any resulting challenges.

## PURPOSE:

To take appropriate action during and following an earthquake to reduce injury and loss of life, prevent subsequent fires and other secondary effects, and facilitate recovery.

## PROCEDURE:

1. Remain as safe as possible while the ground is shaking to prevent injury.

    a. Drop, Cover and Hold On – preferably under a sturdy table or desk and away from windows and other hazards such as tall furniture or heavy items that could fall. Do not stand in doorways.

    b. Stay Inside~~ -~~ – many injuries and fatalities occur from people running out of buildings

    c. If outside, take cover as above and move away from buildings, electrical power lines, and overhanging structures.

2. The ~~Hospital~~Nursing Home Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander (IC) and NHICS team will be responsible for managing the response to the earthquake with the following basic objectives:

    a. Ensure safety and security of all residents, staff, and visitors

    b. Minimize damage to property

    c. Facilitate the recovery of power and return to normal operations

3. Communication to Stakeholders~~ -~~- After completing immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the ~~outage~~incident using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

b. Initiate emergency staff call backs if the response to the earthquake requires extra labor resources not already available on site.

c. Do not d~~D~~isseminate information to the public or the media. Any media or public information inquiries should be routed to the LHH Communications Team via the NHICS team. ~~ONLY with the approval of the LHH CEO or DPH Public Information Officer (PIO).~~

4. Staff Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

a. Employees shall contact the command center to report hazards or to request resources to assist with ~~safe, quality~~ delivery of care.

~~b. Employees shall refer media representatives to the Hospital Incident Command Center at 415-759-4636.~~

5. Ensure Safety of all Persons and Continue Quality Care of Residents

a. Check for injuries and move residents away from windows or other hazards such as shelves with heavy objects overhead.

b. Check every space and every person to determine if anyone is trapped or in need of medical attention.

c. Account for all persons in your neighborhood or department (residents and staff).

d. Complete the Department Operating Status Report (DOSR) and fax it to the command center at 415-504-8313 or deliver to a DOSR bin.

e. Do not use elevators until advised of their safety.

f. Check the environment for fire and respond per R.A.C.E. as needed. ~~and n~~Notify the command center of any fire safety concerns.

g. Check for other hazards such as broken glass, electrical shorts, falling objects such as lights, ceiling tiles, wiring and report to the Command Center.

h. Be prepared for aftershocks. These may be as hazardous as the initial quake.

i. Facility Services shall assess building damage and will notifi~~y~~es the C~~c~~ommand C~~c~~enter of findings.

6. Re-establish normal operations according to essential service priorities in 70-01 B2 Continuity of Operations Plan.

7. Follow appropriate procedures for any resulting effects, such as fire, power outage, or water disruption

**ATTACHMENT:**
None.

**REFERENCE:**
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)

Revised: 18/07/10, 23/06/30 (Year/Month/Day)
Original adoption:

# WATER DISRUPTION PLAN

## POLICY:

Laguna Honda Hospital is committed to providing residents and staff with a sufficient supply of water throughout any emergency event that disrupts the water supply.

## PURPOSE:

To effectively manage a disruption in water service.

## PROCEDURE:

1. The Nursing H~~ospital~~ome Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander and NHICS team shall be responsible for managing the response to the disruption in water service with the following basic objectives:

    a. Ensure an adequate water supply for the safety of residents and staff

    b. Minimize damage to property

    c. Facilitate the recovery of water service and return to normal operations

2. Response staff and NHICS team can use the CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities document as a reference for additional response actions.

~~2.~~3. Communication to Stakeholders -- After completing immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the disruption using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

    b. Initiate emergency call backs if the provision of an adequate water supply requires extra labor resources not available on site.

    c. Disseminate information to the public or the media ONLY with the approval of the LHH CEO or DPH Public Information Officer (PIO).

~~3.~~4. Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

    a. All employees shall contact the command center with questions about the disruption of water service, to report adverse effects, or to request resources to assist with safe, quality delivery of care.

b. Employees shall refer media representatives to the Nursing ~~Hospital~~ Home Incident Command Center at 415-759-4636.

~~4.~~5. Identify sources of potable water

Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount required per day estimated at 1,780 gallons per day for a full census of 780 plus 1,000 staff.

Water for 3 days = 5,340 gallons
Water for 5 days = 8,900 gallons
Water for 7 days = 12,460 gal.

a. There are two 300,000-gallon water tanks east of the east parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed)

b. Bottled water is delivered weekly for office water coolers such that there is between 1200 and 1700 gallons on hand at any given time. We also have an emergency operations MOU in place with the vendor (details with material management).

c. ~~190 gallons of water stored in the kitchen (60 cases of 24 ½ liter bottles)~~ 270 gallons of water stored in Food Service Emergency Storeroom (120 cases of 24 can, 12 ounces per can).

d. ~~164 gallons of juice, soda, and flavored water in kitchen (includes 20 cases of frozen 4 oz. juice, 94/ case; 25 cases of 24 12 oz. soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz. each).~~ 325.5 gallons of juice stored in the Food Service Emergency Storeroom ~~(Apple Juice 64 cases 48ea./4ounce, Diet Cranberry Juice 69 cases 48ea/ 4ounce, Orange Juice 84 cases 48ea/4ounces.~~

~~5.~~6. Conserve potable water until service is restored:

a. Do not flush toilets more than necessary~~. Need parameters: typical is if its yellow, let it mellow if its brown flush it down. Gross but works.~~ only flush for solid waste.

b. Hand hygiene will remain a priority. Encourage alcohol hand sanitizer use unless hands are visibly ~~soiled~~soiled, or staff are caring for a resident with known/suspected CDI infection. ~~Use alcohol hand sanitizer for hand washing.~~

c. Turn off irrigation systems.

d. Use waterless bathing products for resident hygiene as much as possible.

e. Disconnect ice machines.

f. ~~Minimize E~~environmental cleaning will remain a priority. ~~as directed by command center/ infection control branch director to maintain infection control and safety and u~~Use commercially prepared wipes as much as possible for disinfecting surfaces.

g. Use alternate methods for sanitary sewage disposal:

   i. Flush toilets with buckets of pool water. Pools have a total of 32,450 gallons of water. A pump is available, via facilities, to fill buckets on a cart that can be transported for cleaning or flushing purposes.
   ii. If pool water runs out, use commodes and bedpans with liners or plastic bags under toilet seats and empty into waste bags. Follow instruction from command center for bag disposal procedures.

h. If the sprinkler system loses pressure, Facility Services shall activate Facility Services P&P LS-12 Fire Watch.

~~6.~~7. When water service is restored:

a. The Facility Services Department shall check all building systems, including sprinklers to ensure adequate pressure and water flow.

b. The command center shall notify building occupants that the service is ~~restored~~restored, and normal operations can resume.

**ATTACHMENT:**
None.

**REFERENCE:**
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
Facility Services P&P US-6: Utility Systems – Plumbing Systems
Facility Services P&P LS-12: Life Safety Management – Fire Watch
Facility Services P&P US-7: Domestic Water System
Food Services 1.03 Disaster Plan
CDC: Emergency Water Supply Planning Guide: For Hospitals and Healthcare Facilities

Revised: ~~18/09/11~~ 31/05/2023(Year/Month/Day)
Original adoption:

# SMOKE AND TOBACCO FREE ENVIRONMENT

## POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to maintain a smoke and tobacco free environment consistent with State laws and City regulations for the protection and preservation of the health of residents, employees, volunteers and visitors.

2. Smoking and tobacco products are prohibited on the LHH campus, with the exception of smoking in the designated smoking area as described below.

3. Lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame are not permitted and shall be collected from residents by staff for safekeeping.

4. Residents are not permitted to keep tobacco products on their person, in their personal belongings, or in their patient room. Tobacco products will be stored in a central location for safekeeping and usage only in Serenity Park, the designated smoking area. Patients will receive one smoking product at a time

5. Tobacco products brought by visitors, bought for residents, or purchased by residents while Out on Pass will be surrendered in the lobby and picked up by designated unit staff.

6. This policy applies to any tobacco product, any product that emits smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, including nicotine and non-nicotine e-cigarettes, cigarettes, cigars, pipes, pipe tobacco, or chewing tobacco.

7. Buying and selling of tobacco products, products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, between any individuals is prohibited.

8. The prohibition of smoking on the LHH campus applies to staff, vendors, volunteers, and visitors.

9. Residents may only smoke in the designated smoking area when on the LHH campus, in accordance with their individual care plan. Smoking or ingesting cannabis is not permitted in the designated smoking area.

10. Residents with an oxygen tank or concentrator are prohibited from smoking or being within 6 feet of the designated smoking area.

11. During off campus resident related activities:

a. Residents are expected to comply with this policy and according to their care plan.

b. Employees shall comply with this policy when on work time.

**DEFINITION:**

1. The LHH campus means the area owned, operated, maintained, or leased by the City, bordered by Laguna Honda Boulevard, Woodside, Idora and Clarendon and includes all buildings, grounds, parking spaces, and all vehicles owned or operated by LHH or the City.

2. Smoking means inhaling, exhaling, burning, or carrying any lighted, heated, or ignited cigar, cigarette, cigarillo, pipe, hookah, electronic device, or any other device that delivers nicotine or other substances to a person.

3. Tobacco Product means:
   a. any product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, snuff; or

   b. any electronic device that delivers nicotine or other substances to the person inhaling from the device, including, but not limited to, an electronic cigarette, electronic cigar, electronic pipe, or electronic hookah.

**PURPOSE:**

1. To promote a smoke and tobacco free environment;

2. To comply with state and/or local regulations which promote a smoke free work environment;

3. To ensure a healthy, comfortable and safe environment; and

4. To provide leadership, guidance and support in the promotion of a healthy lifestyle.

**PROCEDURE:**

**1. Signage**

a. Signs that advise that LHH is a smoke and tobacco free campus shall be posted at the hospital's entrances.

b. Signs that advise that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are prohibited shall be posted at the hospital's entrances.

c. A designated smoking area has been created for residents' use.

## 2. Applicability

a. Resident Notification, Assessment and Care Planning

i. Applicants and referral sources shall be informed by receipt of the referral packet that LHH is a smoke and tobacco free campus with a designated smoking area for LHH residents.

ii. New residents are given the Smoke and Tobacco Free Environment Policy by Admissions and Eligibility staff at the time of the resident's admission or as soon thereafter as is reasonable.

iii. The resident or surrogate decision-maker acknowledges receipt of the Smoke and Tobacco Free Environment policy and agrees to abide by its requirements by their signature on the House Rules and Responsibilities.

iv. The physician and/or the licensed nurse shall document the resident's smoking and tobacco use history.

v. When indicated, a designated member(s) of the Resident Care Team (RCT) shall provide the resident with smoking cessation education and therapies.

vi. The Smoking Assessment shall be completed by RCT members to determine if a resident has a desire to smoke and if the resident is a safe or unsafe smoker. Assessment and education about smoking and smoking cessation shall be documented in the resident's medical records.

- The frequency of Smoking Assessment shall be completed on admission, re-admission, quarterly, annually, when a resident experiences a cognitive change that affects their safety awareness and judgement.

- Any resident who is deemed safe to smoke, with or without supervision, shall be allowed to smoke in the designated smoking area, at designated times, and in accordance with his/her care plan.

vii. If indicated (e.g., possession of an ignitor), refer to LHHPP #22-12 Clinical Search Protocol

viii. Clinical care plan interventions shall be developed for those residents who have violated the smoke and tobacco free environment policy, and may include,

- Search of a resident's belongings and room, with their consent, for, and safekeeping of, smoking or tobacco product materials.

- Meeting with RCT members to discuss the violation with resident and outline care plan to prevent further smoking or tobacco product violations, which may include repeat searches, engagement in smoking cessation activities, referral to Psychiatry for management of comorbid behavioral health conditions and/or MD.

ix. Those residents who are identified as smokers, who would like to quit smoking shall be offered smoking cessation education and will be evaluated for appropriate therapies with a goal of smoking cessation.

b. Employee and Volunteer Notification

i. Job posting announcements shall include a statement informing applicants that LHH is a smoke and tobacco free campus.

ii. Employees, volunteers, including trainees and students, shall be notified during orientation that smoking is not permitted on the LHH campus. Staff, vendors, volunteers and visitors will need to go off campus to smoke. The designated smoking area is only for resident use.

iii. To facilitate a smoke and tobacco free environment, designated staff shall periodically offer smoking cessation programs for employees.

iv. Volunteers shall be notified that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted at each visit when asked to sign-in with the volunteer kiosk.

c. Visitor Notification

i. Visitors, including contractors, vendors and outpatients, shall be informed that LHH is a smoke and tobacco free campus, and that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted through signage at entrances, applicable agreements, hospital brochures and staff. The designated smoking area is only for resident use.

## 3. Compliance & Safety

a. Employee Obligations

i. The entire LHH community is responsible for complying with the Smoke and Tobacco Free Environment policy, which may include respectfully informing the smoker that LHH is a smoke and tobacco free campus with a designated smoking area for resident use only.

ii. The Smoke and Tobacco Free Environment policy is part of the new employee orientation and annual in-service.

iii. An employee who observes a violation of this policy by a resident is to report the incident to the respective neighborhood nurse manager/charge nurse.

iv. An employee who observes a violation of this policy by a staff member is encouraged to report the incident to the responsible manager for corrective action.

v. An employee who violates this policy may be subject to disciplinary action.

vi. Sheriff Officers who observe noncompliance or are contacted to assist with notifying residents, visitors or employees to comply with this policy may cite the noncompliant individual for violation of municipal or state codes.

b. Safety Obligations

i. For residents who are identified as a smoker or have a desire to smoke, the RCT shall complete the smoking assessment on admission, re-admission, quarterly, annually, when there is a significant change in condition, when a resident is placed on oxygen, when a resident who smokes has delirium affecting cognition and understanding, and/or when a resident who did not smoke at admission begins to smoke.

ii. The RCT shall ensure that residents whose assessments or care plans indicate a need for assisted or supervised smoking have a written plan that assists, supervises, and monitors their smoking. The RCT shall also ensure that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are collected from such residents.

iii. The RCT shall ensure that residents identified, via the required smoking assessment, to have the need for safety equipment (i.e., smoker's apron) will be provided one. These protective devices will be documented and incorporated in a written plan of care that includes monitoring of compliance and effectivity.

- Smoker's aprons will be available to residents in the designated smoking area.

- For residents who refuse to utilize the identified safety equipment required for their safety while smoking, the residents shall not be provided smoking materials (i.e., cigarettes) in the designated smoking area.

iv. The RCT shall review the care plan of residents who are not complying with the terms of this policy to determine if further interventions can be provided to assist the resident with compliance.

- Residents who continue to not comply with the terms of this policy shall receive education on the requirements of the facility policy.

- Residents may risk being deemed ~~not~~ unsafe to smoke in the designated smoking area and smoking materials shall not be provided.

~~ii.~~v. The smoke patrol shall report smoking violations to the Nursing Office.

vi. RCT will address resident's non-compliance by assessing and implementing appropriate interventions.

4. If at any time LHH changes its policy to prohibit smoking, it will allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents.

   a. Residents admitted after the facility changes its policy will be informed of this policy at admission, along with their family members.

**ATTACHMENT:**
None.

**REFERENCE:**
LHHPP 22-12 Clinical Search Protocol
LHHPP 35-01 Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus
LHHPP 75-05 Illicit or Prohibited Drugs and Paraphernalia Possession/Use By Residents or Visitors
CDPH Program Flexibility, Requested 01/13/2014
Laguna Honda House Rules and Responsibilities
Smoking Cessation Assessment (MR 161T)
California Labor Code Sec. 6404.5
California Health and Safety Code Sec. 11362.3
San Francisco Health Code Art. 19F

Revised: 98/01/01, 08/10/01, 08/11/25, 10/04/13, 11/11/29, 14/01/28, 15/11/09, 18/09/11, 19/03/12, 20/10/13, 22/07/12, 22/12/13 (Year/Month/Day)
Original adoption: 92/10/30

# New Nursing Policies and Procedures

# LARYNGECTOMY TUBE CARE

**POLICY:**

1. Physician's order is required for all laryngectomy care.

2. Upon admission, the attending physician may refer any resident with a laryngectomy to ENT/RT and/or other specialists for review and evaluation.

3. Trained registered nurses (RN) or licensed vocational nurses (LVN) will change the laryngectomy (LaryTube) of residents who have had been stable post laryngectomy and LaryTube placement.

4. Emergency respiratory equipment shall always be available at the bedside:
    a. Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline.
    b. Lary Tube of the same type, size - for emergency replacement
    c. Ambu bag with pediatric mask (ordered by physician to keep at bedside)

5. If resident is to use a Heat Moisture Exchanger (HME) valve, an order and RT referral is required.

**PURPOSE:**

To maintain a patent airway and to prevent infection.

**DEFINITIONS:**

Laryngectomy: A surgery to remove part or all of your larynx (voice box). After a total laryngectomy, the trachea is brought to the skin as a stoma and is called a tracheostoma, which no longer has any anatomical connection with the oropharyngeal cavity and digestive tract.

Laryngectomy tube (LaryTube): A hollow, pliable silicone tube that is inserted into the tracheostoma designed to maintain an airway. It has a curvature consistent with the curvature of the trachea following a laryngectomy.

Heat Moisture Exchanger (HME): a device that you use in-line with a breathing tube to keep moisture in your airway.

**PROCEDURE:**

**A. Emergency Airway Care for Resident with LaryTube:**

a. If LaryTube becomes dislodged and stoma is not patent, the licensed nurse is to have another staff person call code blue (Ext. 42999) while the LN stays with the resident and attempts to open the airway.

b. If the resident requires bag valve mask ventilation with an ambu bag for respiratory distress, respiratory failure or cardiac arrest, use a pediatric sized mask with an adult ambu bag for rescue breathing, and mask should be place over the stoma.

i. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15L/min until the physician arrives.

c. During an emergency the physician may choose to immediately insert an endotracheal tube into the stoma, not into the oral airway.

**B. Resident Considerations:**

a. Assess resident: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.
b. Explain the function of the equipment.
c. Provide resident the best method of communication, for example: letter boards, paper and pencil, dry erase board.
d. The licensed nurse is to assess breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.
e. The resident is provided with shower collar//shield during bathing to protect their stoma and airway. Shower collar/shield are obtained in LHH Central Supply Room.

**C. Equipment:**

- Mask and/or plastic apron; goggles, face mask, if needed
- Sterile water
- Sterile gauze 4” x 4”
- Sterile cotton-tipped applicators
- Trach Kit, and LaryTube supplies (Tube Brush, Tube Holder or tracheostomy tie)
- Replacement/Clean Lary Tube
- Water soluble lubricant (KY Jelly, SurgiLube, Xylocaine)
- Sterile clamp (Mayo, Kelly, or Magill) for emergency

**D. Routine LaryTube Change**

Note: The LaryTube disinfection requires a dwell time, so cleaning the current LaryTube requires swapping a clean tube to insert while the old tube is being cleaned. Do NOT throw away the removed tube. It needs to be cleaned and stored, so it can be swapped if necessary.

a. Perform suctioning of the trachea as necessary before changing LaryTube. (Refer to NPP I 2.0 Tracheobronchial Suctioning)
b. Perform Laryngectomy Stoma Care (refer to Tracheostomy Care LHH NPP I 3.0 for site care)
c. Wash hands thoroughly before and after performing this procedure.
d. Put on a mask, goggles, and/or plastic apron if resident has copious secretions.
e. Stand at the resident's side while suctioning or cleaning the Larytube.
f. Remove the soiled dressing from around the stoma and discard.
g. Observe the skin surrounding the stoma for evidence of irritation or infection.
h. Wash hands.
i. Prepare the sterile field on the bedside table.
j. Open the tracheostomy care set on sterile field and prepare the equipment including

replacement LaryTube.
k. Place the paper drape across the resident's chest.
l. As needed, removes tracheostomy mask.
m. Hold the LaryTube in place and remove the HME system component from the tube as needed.
n. Release one side of the TubeHolder (trach tie) and remove the LaryTube from the stoma using a slow, gentle motion.
o. Place the removed LaryTube in the sterile water basin.
p. Remove gloves, perform hand hygiene and don sterile gloves.
q. Rinse the LaryTube with sterile water to remove any disinfectant residues. Gently shake off excess water or dry with gauze.
r. Verify the new or cleaned LaryTube is the correct size.
s. Carefully inspect the Larytube before each use (i.e., before insertion). Do not use the product if damaged (e.g., tears, cracks, or crusts) and obtain a replacement.
t. If needed, lightly lubricate the LaryTube with water soluble lubricant contamination.
u. Gently inserts the LaryTube into the trachostoma and attaches with TubeHolder or tracheostomy tie.
v. Discard used equipment. Remove and discard gloves and wash hands.

**E. Cleaning of LaryTube and Storing for Next Use**

a. Rinse the LaryTube with sterile water.
b. Clean the inside of the tube with Tube Brush.
c. Clean the holes of a fenestrated tube (if resident has this type of tube) with a Provox Brush
d. In a clean basin, place the LaryTube in disinfectant with one of the following methods: (obtain solution from pharmacy)
    i. Ethanol 70% for 10 minutes
    ii. Isopropyl alcohol 70% for 10 minutes
    iii. Hydrogen peroxide 3% for 60 minutes
e. Rinse the Brush after use (reusable for single patient use, replace after 4 weeks or PRN)
f. After dwell time, rinse the LaryTube in sterile water and allow to dry.
g. When not in use, store the cleaned/disinfected LaryTube in a clean and dry container (i.e. denture cup) at room temperature. Protect from direct sunlight.
h. Do not use the device until it is completely dry. Inhalation of disinfection fumes can cause severe coughing or airway irritation.
i. If the LaryTube looks dirty or has air dried in an area with a risk of contamination, the device should be cleaned and disinfected before use.
j. The LaryTube may be used for a maximum of 6 months. Replace earlier if damaged or as needed.
k. If resident is using HME, do not lubricate the HME holder, HME cassette or any accessory that is held by the LaryTube because it may lead to accidental detachment.

**F. Suctioning: See Tracheobronchial Suctioning (LHH NPP I 6.0)**

**G. Documentation**

a. The licensed nurse is to document pertinent information, including the type and size of the tracheostomy in the electronic health record.

**REFERENCES:**

3

PROVOX LaryTube Manufacturer Instructions for Use
https://www.atosmedical.us/wp-content/uploads/sites/2/2022/12/90734_provox-larytube-manual_2022-03-14_web.pdf

Mosby's Clinical Skills: Tracheostomy Tube: Care and Suctioning: https://point-of-care.elsevierperformancemanager.com/skills/388/quick-sheet?skillId=GN_24_4&virtualname=sanfrangeneralhospital-casanfrancisco

**CROSS REFERENCE:**

Tracheostomy Care LHH NPP I 3.0)
Tracheobronchial Suctioning (LHH NPP I 6.0)
Tracheostomy Management/Laryngectomy Care LHH HPP 27-05
Nursing P&P I 5.0 Oxygen Administration

Reviewed: 2023/

Approved: 2023/

# CHANGE OF SHIFT HAND-OFF (NURSING)

**POLICY:**

1. It is the policy of Laguna Honda Hospital (LHH) to make successful resident/patient hand-offs an organizational priority and expectation hospitalwide.

2. It is the policy of LHH to provide the safest care and to recognize the importance of effective communication, especially during resident/patient hand-offs, to prevent resident/patient harm.

3. LHH will use a standardized approach for nursing hand-off communications per the instructions specified in the Change of Shift Hand-off Standard Work.

4. Standardized hand-off will be completed by Licensed Nursing (LN) staff and Certified Nursing Assistants (CNA)/Patient Care Assistants (PCA) at each change of shift hospitalwide, and in a timely way to ensure delivery of care and services (Joint Commission, 2017).

5. Standardized nursing hand-off reports will include face-to-face communication to promote opportunities to clarify information/ask questions and will include the use of standardized written templates, and utilization of the EHR (Joint Commission, 2017).

6. Situation-Background-Assessment-Recommendation(s) (SBAR) is the preferred communication technique to provide a hand-off (Zuckerberg Hospital, Administrative Policy Number: 8.03).

**PURPOSE:**

To improve the effectiveness of communication for LN staff and CNAs/PCAs by defining the structure on how and when to exchange information during hand-off, and to ultimately promote resident/patient safety.

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**DEFINITIONS/BACKGROUND INFORMATION:**

**Hand-off:** The transfer and acceptance of resident/patient care responsibility achieved through effective communication. It is a real-time process of passing resident-specific/patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the resident's/patient's care (Joint Commission, 2014).

**SBAR:** A structured communication technique deigned to convey a great deal of information in a succinct and brief manner. SBAR stands for:

- **S**ituation-What is happening now, chief complaints, any acute change, etc.
- **B**ackground-What factors led up to this event/change, pertinent assessment information, vital signs, etc.
- **A**ssessment-What do you see, what do you think is going on, etc.
- **R**ecommendation(s)-What action do you propose, what do you think should be done, what is the plan of care for the resident/patient, explanation of what the resident/patient needs and when, etc.

**Sender of 'Off-going' Staff:** Provides the information about the resident/patient for the handoff (Arora & Farnan, 2023).

**Receiver or In-coming Staff:** Receives the information and then assumes care of the resident/patient (Arora & Farnan, 2023).

**Shift Change/Change of Shift:** The transfer of responsibility when one caregiver finishes and another one begins their shift (Arora & Farnan, 2023).

**PROCEDURE:**

A. **General Nursing Hand-off Process Recommendations for Success** (Joint Commission, 2017)

1. Conduct face-to-face hand-off communication between senders and receivers in a location free from interruptions.
2. Utilize the face-to-face hand-off structure as an opportunity to ask questions and clarify resident/patient information.
3. Hand-offs should be highly reliable, conducted in a high-quality manner for every resident/patient, every shift, with every transition of care.
4. Write-down, repeat-back, and/or read-back, as appropriate, to verify information received.
5. After all pertinent information is communication in the resident/patient hand-off, time must be allotted to review relevant chart information and ask/answer any questions that the receiver may have about the resident/patient.

**B. Resident/Patient Assignment by CN**

1. The CN will complete the assignments prior to the start of change of shift hand-off report.

**C. Change of Shift Hand-off: Charge Nurse (CN)**

1. For additional details, refer to Standard Work: 'Change of Shift Hand-Off for Charge Nurse (CN)' (Attachment A).
2. Upon arrival to the neighborhood for start of the shift, the CN will go to:
    a. Long-Term Care Areas: Report room behind Nurses' Station 2
    b. Pavilion Mezzanine SNF: Meadow Conference Room
    c. Pavilion Mezzanine Acute: Nurses' Station
3. Shift hand-off to occur at the following time:
    a. 0710-0730 for AM to DAY shift
    b. 1510-1530 for Day to PM shift
    c. 2310-2330 for PM to AM shift
4. The off-going CN will ensure that all on-coming staff are present in the report room.
5. The CN will maintain an environment conducive to listening and hearing critical information (e.g., ensure no side conversations, minimize interruptions, minimize distraction).
6. The CN will utilize the 'EHR Kardex' to guide their hand-off report.
7. Using the '24-Hour Hand-off Report', the CN will give the hand-off report on every resident, highlighting new interventions or changes in the residents'/patients' condition (Attachment B).
8. The on-coming CN will take notes using the '24-Hour Hand-off Report Form' (Attachment B).
9. The CN should pay close attention to any staff who may be floating to the neighborhood to ensure that all key information about the resident(s)/patient(s) is received.
10. At the end of the CN hand-off report, the CN will provide time to clarify any questions that the in-coming staff may have.

**D. Change of Shift Hand-off: Licensed Nurse (LN)**

1. For additional details, refer to Standard Work: 'Change of Shift Hand-Off for Licensed Nurse (LN)' (Attachment C).
2. Upon arrival to the neighborhood for start of the shift, the LN will go to;
    a. Long-Term Care Areas: Report room behind Nurses' Station 2
    b. Pavilion Mezzanine SNF: Meadow Conference Room
    c. Pavilion Mezzanine Acute: Nurses' Station
3. Shift hand-off to occur at the following time:
    a. 0710-0730 for AM to DAY shift
    b. 1510-1530 for Day to PM shift
    c. 2310-2330 for PM to AM shift

4. The LN will listen to the off-going CN give their hand-off report.
5. The LN should take notes on the 'LN 24-Hour Change of Shift Report Form' (Attachment D).
6. Once the off-going CN is complete with their hand-off report, the out-going LN will complete their hand-off with the in-coming LN.
7. The LNs should utilize the 'EHR Kardex' to guide their hand-off report utilizing the WOW.
8. The out-going LN will utilize the 'LN 24-Hour Change of Shift Report Form' (Attachment D) and provide hand-off report on every resident within the LN's assignment, highlighting new interventions/new orders, changes in resident condition, and any safety concerns.
9. The in-coming LN will utilize the 'LN 24-Hour Change of Shift Report Form' (Attachment D) and take notes on the form capture resident/patient hand-off information.
10. At the end of the LN hand-off report, the out-going LN will provide time to clarify any questions that the in-coming LN may have.

**E. Change of Shift Hand-off: PCA/CNA**

1. For additional details, refer to Standard Work: 'Change of Shift Hand-Off for CNA/PCA' (Attachment E).
2. Upon arrival to the neighborhood for start of the shift, the in-coming CNA/PCA will go to:
    a. Long-Term Care Areas: Report Room behind Nurses' Station 2
    b. Pavilion Mezzanine SNF: Meadow Conference Room
    c. Pavilion Mezzanine Acute: Nurses' Station
3. Shift hand-off to occur at the following time:
    a. 0710-0730 for AM to DAY shift
    b. 1510-1530 for DAY to PM shift
    c. 2310-2330 for PM to AM shift
4. The off-going CNA/PCA will be responsible for call light coverage and response that go off during the shift change and will remain rounding on residents while change of shift CN and LN handoff is occurring.
5. The in-coming CNA/PCA will listen to the CN hand-off report and listen to the LN hand-off report and takes notes on the 'CNA/PCA Shift-to-Shift Handoff Form' (Attachment F).
6. At the completion of the CN and LN reports, the off-going and the on-coming CNAs/PCAs will huddle.
    a. The off-going CNA/PCA will provide any additional information to the in-coming CNA/PCA and discuss any unique needs of the resident's individualized Purposeful Rounding Plan (e.g., view Person-Centered Information section of Kardex).
    b. If time allows, round on residents/patients together, particularly with new or specialized needs, or those who with any recent change in condition.
7. At the completion of the off-going and in-coming CNA/PCA huddle, the off-going CNA/PCA will endorse (face-to-face discussion) to the off-going CN that they have provided a hand-off to the in-coming CNA/PCA.

**REFERENCES:**

Arora, V. & Farnan, J. (2023). Patient handoffs. UpToDate, accessed on 8/18/2023, at https://www.uptodate.com/contents/patient-handoffs?search=handoffs&source=search_result&selectedTitle=1~11&usage_type=default&display_rank=1

The Joint Commission (2017). Inadequate hand-off communication. *Sentinel Event Alert, Issue 58.*

The Joint Commission Center for Transforming Healthcare. Improving transitions of care: Hand-off communications. Oakbrook Terrace, Illinois: The Joint Commission, 2014.

**CROSS REFERENCE:**

Zuckerberg San Francisco General, Patient Hand-off and Report with Safe Communication.
Administrative Policy Number: 8.03

**ATTACHMENT / APPENDICES:**

Attachment A: Standard Work: Change of Shift Hand-Off for Charge Nurse (CN)
Attachment B: Charge Nurse 24-Hour Hand-off Report Form
Attachment C: Standard Work: 'Change of Shift Hand-Off for Licensed Nurse (LN)
Attachment D: LN 24-Hour Change of Shift Report Form
Attachment E: Standard Work: 'Change of Shift Hand-Off for CNA/PCA
Attachment F: CNA/PCA Shift-to-Shift Handoff Form

New: Submitted by Kathleen MacKerrow & Maria Antoc

Revised: _____

Reviewed: _____

❒ Reviewed by _____ and no revision recommended at this time.

Approved: _____

For Ghe use only:
Date sent to Policy Reviewer _____
Date received from Policy Reviewer _____
Date reviewed by NEC _____
Date approved by NEC _____
Date routed to MEC _____
Date emailed to Karina _____

# Revised Nursing Policies and Procedures

# RESIDENT IDENTIFICATION AND COLOR CODES

**POLICY:**

1. Each resident is to wear a legible wrist identification band with resident name, hospital number and have a photograph on the Medication Administration Record (MAR). Any member of nursing staff may change wrist bands as needed.

2. Residents requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of ~~wristbands with adhesive dots for associated precautions and safety alerts~~stickers placed on::
    - Bed card (above bed)
    - Hallway
    - ~~2.~~ Mobility devices (wheelchairs, geri-chairs, canes, front wheel walkers, etc.)~~.~~

3. The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual resident needs and risks.

**PURPOSE:**

To promote resident safety by ensuring quick and accurate identification of high-risk diagnoses and problems, and special needs approaches.

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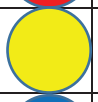
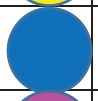
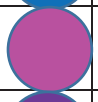
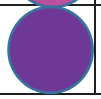
**PROCEDURE:**

**A. Color Coding Grid Table**

| COLOR OR SYMBOL | COLOR OR SYMBOL | HALLWAY, MOBILITY DEVICES, & BED CARD |
|---|---|---|
|  | FALLING STAR | FALL RISK |
|  | RED | ALLERGIES |
|  | YELLOW | DIABETES |
|  | BLUE | SEIZURE RISK |
|  | PINK | ASPIRATION RISK |
|  | PURPLE | SPECIAL APPROACH |

~~A.~~

| ~~Colors~~ | ~~Adhesive Sticker Placed on ID Wristband~~ | ~~Bed Card Stickers~~ |
|---|---|---|
| ~~No Stickers~~ | ~~No Precautions~~ | ~~N/A~~ |
| ~~Red~~  | ~~Allergies~~ | ~~N/A~~ |
| ~~Yellow~~  | ~~Diabetic~~ | ~~Diabetic~~ |
| ~~Blue~~  | ~~Seizure~~ | ~~Seizure~~ |
| ~~Hot Pink~~  | ~~Aspiration~~ | ~~Aspiration~~ |
| ~~Purple~~  | ~~N/A~~ | ~~Unpredictable, aggressive behavior, uses special or cautious approach~~ |

## B. Safety Alerts

1. Care Alert (Confidential Resident Information)


2. Dialysis Care Alert (e.g., NO BP/IV on Right Arm)


3. Fall Risk (Star on Room Name Plate)

## ~~C. Wristbands~~

~~1. Obtain wristbands from central supply and colored adhesive stickers.~~

~~2. Apply associated colored stickers onto label that will be printed~~

~~3. To print wristbands:~~
~~Log onto LCR~~
~~Select Resident's name~~
~~On the left frame, scroll down then click "Clerical Fxns" link~~
~~Click "Print/Send Pt Info" link~~
~~Click "Print Patient Info" link~~
~~From the list of cases, click "Next Page" until you see the resident current Hospital Service Code with no Discharge Date.~~
~~Click "Resident Current Hospital Service Code"~~
~~Click "LHH Wristband Printing~~
~~"Wristband Generated" will be displayed~~

~~4. Use colored dot stickers for the following precautions (Refer to Procedure A: Color Coding Grid Table)~~

## ~~D.~~C. Documentation

- Document precautions in Electronic Health Record (EHR)
- Document, in Care Plan, any refusals by residents who do not want their name or color codes posted

**CROSS REFERENCE:**

LHHPP 26-02 Management of Dysphagia and Aspiration Risk

Revised: 2011/11, 2005/0, 2010/01; 2011/04/26, 2019/03/12, 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

# TRACHEOSTOMY CARE

**POLICY:**

1. Physician's order is required for all tracheostomy care.

2. The **first tracheostomy tube** change will be performed by Ear, Nose, & Throat (ENT) Physician.

3. Cuffed tracheostomy tubes: Cuffed tracheostomies are **only** changed by ENT.

4. Upon admission, the attending physician may refer any resident with a tracheostomy to the ENT and/or other specialists for review and evaluation. If the primary physician determines the referral is not indicated, the reason will be documented in the medical record. Referral to the ENT, Speech Language Pathologist (SLP) and/or Respiratory Therapists (RT) shall be made via e-referral.

5. Residents admitted with a speaking valve will also be referred to Speech pathology per HWPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir.

6. Emergency respiratory equipment shall always be available at the bed-side:
    a. Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline
    b. Tracheostomy of the same type, size (including inner cannula)- for emergency replacement
    c. Ambu bag if ordered by physician

7. The disposable inner cannula (DIC) should never be cleaned and reused. It is intended for a one-time use only and is changed at least twice daily and as needed. Discard the used cannula and insert a new one, touching only the external portion. Lock it securely in place.

~~7.~~8. Tracheostomy site care should be perfomed daily and PRN. Site assessment should be performed and documented QShift to determine status of dressing.

~~8.~~9. Subsequent replacements of the outer cannula standard tracheostomy tubes will be carried out by nursing at least once per month. If an urgent appointment is needed, phone the Surgical Clinic and mark "urgent" on the ENT e-referral. (Note: if an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy).

~~9.~~10. With the exception of those residents requiring specialized tracheostomy tubes, trained registered nurses (RN) or licensed vocational nurses(LVN) will change the cuffless tracheostomy tube of residents who have had a tracheostomy for more than three weeks old and who have been seen by ENT for initial change. The type, tube size, and day of change are to be ordered by the physician.

~~10.~~11. Non-standard Tracheostomy Tubes for Special Needs (e.g., extra-long tracheostomy tubes): If a resident has a non-standard tracheostomy tube, the resident shall be referred to ENT for all tracheostomy tube changes. A spare non-standard tracheostomy tube will be kept at the bedside to be used only in an emergency (e.g., tracheostomy tube falls out).

**PURPOSE:**

To maintain a patent airway and to prevent infection.

**PROCEDURE:**

**A. Emergency Care for Dislodged or Removed Tracheostomy Tube:**

1. If the tracheostomy tube of a fresh tracheostomy becomes dislodged or pulled out, the licensed nurse is to have another staff person call code blue (Ext. 42999) ~~and the ward physician~~ while ~~s/he~~ the LN stays with the resident and attempts to open the airway.

2. In a **new** tracheostomy (less than 7 days) do not attempt to reinsert another tracheostomy tube. Keep the wound open with a clamp (Mayo or Kelly) or use the stay sutures if they are present.

3. In a **fresh** tracheostomy (less than 21 days), a smaller size or a size below the existing tracheostomy tube should be at the bedside to keep the stoma open until the physician arrives.

4. In a more chronic, well-established tracheostomy, may keep tracheostomy open with a tracheostomy set, one size smaller, kept in treatment room.

5. During an emergency the physician may choose to immediately insert an endotracheal tube by mouth whether or not the tracheostomy is new or has an established tract.

6. The physician may transfer the resident with a fresh tracheostomy to an emergency room for acute surgical consultation.

**B. Emergency Care Using the Resuscitation Bag:**

1. Hyperextend the resident's neck, UNLESS the resident has had a recent cervical injury, has a cervical brace, or is on cervical precautions.

2. If the tracheostomy tube has been accidentally removed and the resident does not have a complete upper airway obstruction, a gaping stoma, or a laryngectomy, a Bag Valve Mask (BVM) resuscitation device may be used to ventilate the resident by mouth while covering the stoma.

3. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15L/min until the physician arrives.

4. **Nursing Alert:**

   a. New tracheostomy
      i. Manipulation of neck ties and face plate should be minimized.
      ii. Residents who are likely to remove or manipulate the tracheostomy tube may have a physician's order for mitten restraints if assessed as appropriate by Resident Care Team.
      iii. A suction machine is to be readily available.
      iv. A sterile clamp (Kelly or Mayo) and a sterile endotracheal tube and tracheostomy tube set matching the type of tube, but one size smaller that the tube the resident has in place, are to be kept in a plastic bag in the top drawer of the bedside stand.

   b. Tracheostomy emergency replacements sets should be kept in the bedside stand, sterile replacement tube sets and clamps may be kept in the treatment room. Keep one set for each size and type tracheostomy tube in use on the unit.

c. Aspiration: If food or liquid is noted during suctioning, inform the resident's physician immediately. Consider referral to speech therapy for urgent swallowing evaluation

**C. Resident Considerations:**

1. Assess resident: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.

2. Explain the function of the equipment. Inform the resident and significant others that speaking with a tracheostomy is difficult.

3. Provide resident the best method of communication, for example: letter boards, paper and pencil, dry erase board.

4. The resident with a tracheostomy will be positioned at approximately 45 degrees or sitting upright when possible with position changes about every 2 hours to ensure ventilation to all lung segments and to prevent secretion accumulation around the tracheostomy tube.

5. The licensed nurse is to assess breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.

6. The resident may be provided with shower bib during bathing to protect his/her airway. Shower bibs are obtained in LHH Central Supply Room.

**D. Equipment**:

Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
Suction equipment
Sterile connecting tubing and catheter plug
Mask, goggles and plastic apron
Sterile clamps (Mayo, Kelly, or Magill)
Water soluble lubricant
Sterile saline solution
Bedside waste bag
10 mL Luer syringe to inflate/deflate cuffed tubes
Bag Valve Mask
Oxygen source

**E. Routine Tracheostomy Care: Changing <u>Inner Cannula</u> of Cuffed or Cuffless Tracheostomy:**

1. Preparations:

a. Perform suctioning of the trachea and pharynx as necessary before changing inner cannula. (Refer to NPP I 2.0 Tracheobronchial Suctioning)
b. Wash hands thoroughly before and after performing this procedure.
c. Put on a mask, goggles, and/or plastic apron if resident has copious secretions.
d. Stand at the resident's side while suctioning or cleaning the tracheostomy tube.
e. ~~Label the sterile~~<u>Sterile</u> saline solution ~~with the date opened, time, and nurse's initials. Discard after 24 hours.~~<u>is single use only and should be discarded after procedure is completed.</u>
f. Remove the soiled dressing from around the stoma and discard.
g. Observe the skin surrounding the tracheostomy for evidence of irritation or infection.

h. Wash hands.
i. Prepare the sterile field on the bedside table.
j. Open the tracheostomy care set on sterile field and prepare the equipment
k. Put on the sterile gloves. Keep dominant hand sterile throughout the procedure. Use the other hand as clean hand to handle unsterile items.
l. Use your sterile-gloved hand to remove the remaining contents of the set onto the sterile field and separate the basins.
m. Use your clean gloved hand to pour the solution.

2. Tracheostomy site skin care:

a. Tracheostomy site skin care should ~~done every shift~~performed daily and PRN.
b. Cleanse the skin around the stoma site. If crusts are present, soften them with sterile 4" x 4" gauze slightly moistened with sterile saline.
c. Rinse with a sterile saline-soaked 4" x 4" gauze and pat dry. Avoid snagging loose threads on the tracheostomy tube because they could be inhaled.
d. Cleanse external areas of tracheostomy tube with sterile cotton-tipped applicators moistened in the saline. Rinse areas with sterile saline-dipped applicators. Discard into bedside bag.
e. Place a dry drain sponge under and around the tracheostomy tube. Reserve the extra tracheostomy dressings as needed for changes in between tracheostomy care.
f. Replace the Velcro fastening tracheostomy tie if soiled.
g. Discard used equipment. Remove and discard gloves and wash hands.

**F. Changing Tracheostomy Tube of a Cuffless Tracheostomy - Done Monthly and PRN**

1. Prepare equipment:

a. Refer to Section E1 above to set up equipment for cleaning solutions and suctioning catheter.
b. Open the packages containing the replacement tracheostomy tube and sterile 4" x 4" gauze.
c. Squeeze a small amount of water soluble lubricant on the sterile 4" x 4" gauze
d. Suction the resident if necessary.
e. Insert obturator into the outer cannula of the new tracheostomy tube.
f. Lubricate the tracheostomy tube well.

2. If difficulty occurs:

If the resident goes into a laryngeal spasm, or the resident has difficulty breathing, or you cannot get the tracheostomy tube in place, as an emergency measure, quickly insert the mayo clamp into the stoma opening and spread the clamp. This is to be done only in case of emergency. Call the physician immediately

3. Changing the cuffless tracheostomy tube monthly and as needed:

a. Use clean-gloved hand to cut the tracheostomy tape attached to the tracheostomy tube that you are going to change.
b. Remove old tracheostomy tube.
c. With sterile-gloved hand, insert the new tracheostomy tube into the stoma, using a downward motion.
d. Quickly remove the obturator.
e. Using sterile-gloved hand, insert the inner cannula and lock in place according to the type of tracheostomy tube in use. That is, a Shiley tube twists into place and a Portex tube snaps in place.

f. Velcro/fasten the tracheostomy tie.
g. Apply a sterile drain sponge around the tracheostomy tube.

**G. Cuffed Tracheostomy Tubes**: **Only Changed by ENT physician**

If an emergency occurs during the day shift, notify the physician. (MSPP #D06-01 Tracheostomy Management.) If an emergency occurs with a cuffed tracheostomy tube during am or pm shift, follow emergency procedures on page 1, part A.

1. The attending physician will document in the medical record if a resident is admitted with a cuffed tracheostomy tube and will write specific orders regarding cuff inflation/deflation.

2. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedure/precautions with Licensed Nurse.

**H. Speech with a Tracheostomy Tube:**

Consult with Speech Language Pathologist and/or Respiratory Therapists for information on the care and use of speaking devices.

**I. Documentation:**

1. The licensed nurse is to document pertinent information, including the type and size of the tracheostomy in the electronic health record.

2. Tracheostomy care during routine care or tube changes:

   For Acute care, residents with tracheostomies under 6 weeks in progress notes:

   a. Resident tolerance of tracheostomy care procedure such as cyanosis or respiratory distress.
   b. Appearance of the tracheostomy skin site
   c. Characteristics of secretions

   For chronic care residents with stable tracheostomies, document above on weekly, monthly summaries.

3. Tracheal Cuff care:

   a. Tracheal cuff release time.
   b. Amount of air used for cuff inflation.
   c. Any changes in respiratory status during deflation/inflation.
   d. Amount, color and consistency of secretions

4. Inform physician and document if the resident develops a cough, chest pain, fever, rales, dullness of the chest on percussion, or stoma site develops signs of infection.

**REFERENCES:**

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

Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

Mosby's Clinical Skills, Tracheostomy Tube: Care and Suctioning

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

**CROSS REFERENCES:**

LHHPP File: 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passey-Muir.
LHHPP File: 27-05 Tracheostomy Management

Nursing P&P I 2.0 Tracheobronchial Suctioning
Nursing P&P I 5.0 Oxygen Administration

**ATTACHMENTS/APPENDICES**

None

Revised: 2000/09, 2008/08, 2016/09/13, 2019/03/12; 2019/05/14; 2022/07/12

Reviewed: 2022/07/12

Approved: 2022/07/12

## Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis

Coordination of care of the resident undergoing outpatient hemodialysis is the joint responsibility of the LHH unit physician and nurse, and the Outpatient Dialysis Center nephrologist and nurse. There are written agreements between Laguna Honda Hospital and community dialysis centers signed by the LHH Medical Director, along with LHH Medical Staff Policies and Procedures. The LHH attending physician is responsible for the medical management of all LHH residents, including those receiving hemodialysis.

**Background:**

Medical management of residents requiring hemodialysis for the treatment of end stage renal disease (ESRD) is by definition complex. To assure quality care, promote communication and coordination of care, the following guidelines have been established.

**Guidelines:**

Prior to resident transport to the outpatient dialysis center, the LHH unit nurse will:

1. Prepare the resident for transport.
2. Weigh the resident.
3. Consult with pharmacist and/or physician regarding timing of anti-diabetic medications and water soluble medications as needed.
4. Report any clinically relevant information about the resident's physical and emotional status or any new physician orders to the dialysis nurse or technician.
5. Arrange for a tray to be served upon return from dialysis; or send a bag lunch with resident when indicated.
6. Complete the ~~top portion of the Dialysis Communication Form~~ Hemodialysis Communication Form in the EHR progress/nursing notes and ~~it via s~~ecure~~d~~ fax to the dialysis center or route via the EHR.
7. At any time the LHH physician or nephrologist may choose to communicate pertinent information by phone as well as written progress note with regards to the resident's condition or change in treatment plans, etc.

Origination: 8/2006

Revised: 2/2008; 07/14/2015

Reviewed: 07/14/2015, 6/23/23

Approved: 07/14/2015

# Revised Food and Nutrition Policies and Procedures

# Laguna Honda Hospital and Rehabilitation Center
# Clinical Nutrition - Diet Manual

Updated: ~~November 13, 2019~~July 6, 2023
~~Reviewed: August 27th, 2014, August14th, 2015~~

# Table of Contents

## Contact Information for Clinical Nutrition Staff

| Name | Position | Desk Phone ext.# | Pager # |
|---|---|---|---|
| Atlas, Zoe<br>• N4<br>• S5 (Marina – 20's & Pacifica – 30's) | Dietitian | 4-3098 | 1844 |
| Cizas, Grace<br>• PM-Rehab/SNF-Acute (rms 48-51)<br>• S6 (Marina – 20's & Pacifica – 30's) | Dietitian | 4-3097 | 1843 |
| Cecconi, Loretta | Chief Dietitian | 4-3367 | 2533 |
| Cruz, Monica<br>• N1<br>• NM (Cedar – 10's & Redwood – 40's) | Dietitian | 4-4031 | 1860 |
| Dantoc, Judy<br>• S2 | Dietitian | 4-3389 | 1859 |
| Kataria, Sheetal<br>• N6<br>• N5 (Cedar- 10's & Redwood- 40's) | Dietitian | 4-3362 | 1086 |
| Moghbel, Neda<br>• N3<br>• N5 (Cypress-20's & Juniper 30's) | Dietitian | 4-3385 | 1919 |
| Podesta, Danielle<br>• S3<br>• S6 (Buena Vista-10's & Sierra-40's) | Dietitian | 4-4589 | 0514 |
| Shiels, Rebecca<br>• N2<br>• NM (Cypress-20's & Juniper-30's) | Dietitian | 4-3356 | 7502 |
| Wildman, Clair<br>• S5<br>• N1 (Cypress – 20's & Juniper – 30's) | Dietitian | 4-3020 | 7814 |

Diet Technician will assist with MDS, screening & Quarterlies as assigned by Registered Dietitian

| | | | |
|---|---|---|---|
| Parks, Alicia<br>• S2, S4, NM, N4 (MDS) | Diet Tech | 4-3340 | 1778 |
| Subia, Adam<br>• PM, S5, S6 (MDS) CBORD/Menu Mgmt | Diet Tech | 4-4623 | 7759 |
| Wan, Elisa<br>• S3,N1, N2, N3, N5, N6 (MDS) | Diet Tech | 4-3087 | 1538 |

| | |
|---|---|
| Diet Office | 4-5776 |

# INTRODUCTION

~~This Diet Manual was developed for use at Laguna Honda Hospital and Rehabilitation Center with the continuing efforts and combined knowledge of the Registered Dietitians (RDs). It is the objective of the Diet Manual to incorporate current dietary guidelines for U.S. populations with principles of feeding the elderly, as well as the chronically ill or young disabled resident.~~

~~As consultant members of the interdisciplinary teams, RDs provide medical nutrition therapy (MNT) to hospital residents; document nutrition assessments, develop care plans, and promote optimal nutritional status throughout the resident's stay at the hospital. The RDs and the dietetic technicians (DTRs) visit residents to assist with food choices and to increase satisfaction with meal service. Through diet modification, individualized counseling and specialized nutrition therapy, the RDs participate in disease management and provide effective, comprehensive resident care. Nutrition education for staff and residents and nutrition counseling for discharge are included in these resident services.~~

~~The Laguna Honda Diet Manual serves as a guideline and information tool about diets at Laguna Honda Hospital for providers, nursing and nutrition and foodservice staff within Laguna Honda. The Laguna Honda Diet Manual has been developed by Clinical Nutrition and approved by the medical staff.~~

~~The RD use the Diet Manual to plan regular and therapeutic menus 1. adjust diet prescriptions to meet resident food preferences, 2. evaluate a resident's individual nutrient needs, 3. determine nutrient adequacy of the daily diet, and 4. develop resident education materials. The Ps use this resource to specify appropriate dietary regimens and diet prescriptions. Dietary/Nursing/Ancillary personnel on the interdisciplinary team use the manual in establishing a common language of communication for quality nutrition care.~~

## ~~Introduction~~

The Laguna Honda Diet Manual serves as a guideline and informational tool for Laguna Honda Hospital (LHH) dietetic personnel and licensed healthcare practitioners acting within the scope of their professional licensure or certification. The Laguna Honda Diet Manual is tailored to the therapeutic needs of the population.

Once a diet is ordered, the diet is processed and a meal tray is prepared for the resident by Food and Nutrition Services. It is the role of the dietitian to accommodate the resident's nutrient needs with appropriate interventions within the patient's personal, cultural, and religious food preferences.

## Nutritional Adequacy

All LHH Diets shall provide food of the quality and quantity to meet each patient's needs in accordance with the most current Recommended Dietary Allowance (RDA) and Daily Reference Intakes (DRIs) adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and Minerals which do not have DRI/RDAs established and are not readily available in the USDA or vendor database cannot be evaluated for complete nutritional adequacy in the patient menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team works to individualize nutritional care of the patient considering their food preferences.

## Diet Liberalization

Therapeutic diets are considered both textured modified diets as well as therapeutics diets. The Regular diet is not considered a therapeutic diet. Diet liberalization is a nutritional component that may enhance the quality of life and nutritional status of older adults residing in health care communities. According to Federal Regulations (F692), "diet liberalization could be beneficial to minimize restrictions, such as therapeutic or mechanically altered diet, and provide preferred foods before using supplementation." The registered dietitian will assess, evaluate, and recommend appropriate and individualized nutrition interventions. Collaboration

between the interdisciplinary team and the patient and/or decision maker is necessary to assess the risks versus benefits of liberalizing a therapeutic diet.

**28-Day Cycle Menu Analysis**

The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals, and vitamins. Totals, averages, and standard deviations were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting (415) 759-4589.

The Laguna Honda Diet Manual ~~describes the Regular diet, texture modifications, therapeutic diets commonly and the enteral products currently stocked in the department. F~~format of each diet is as follows:

~~I.~~ I. ~~Purpose~~ denotes characteristics of each diet as a modification of the ~~Regular~~ diet.

~~I.~~II. Indications lists specific medical concerns for which the diets can be used.

~~II.~~III. Adequacy indicates the nutritional adequacy of the diet based on the Dietary Reference Intakes (DRI), ~~*[(DRI for Calcium, Phosphorous Magnesium, Vitamin D and Fluoride(1997); DRI for thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin and Choline(1998); DRI for Vitamin C, Vitamin E, Selenium, and Carotenoids (2000); DRI for Vitamin A, Vitamin K, Arsenic, Boron, Chromium, Copper, Iodine, Iron, Manganese, Molybdenum, Nickle, Silicon, Vandium and Zinc (2001); DRI for Energy, Carbohydrates, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids (2002/2005); DRI for Calcium and Vitamin D (2011)]*~~ and the Recommended Daily Allowance (RDA)~~., 1989.~~ ~~Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and Minerals which do not have DRI/RDAs are not readily available in the USDA or vendor database cannot be evaluated for complete nutritional adequacy in the patient menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team works to individualize nutritional care of the patient considering their food preferences.~~

~~III.~~ IV. Approximate Composition lists approximate calories, protein, and carbohydrate, fat and, as needed, specific nutrients provided in each diet.

V.
~~II.~~ Suggested Meal Patterns show basic meal-planning guides with approximate amounts of foods specified according to dietary restrictions. ~~-~~The dietitian ~~RD~~ may adjust meal patterns to meet a resident's cultural, ethnic, food likes and dislikes and meal service preferences.

~~III. There is additional nutritional information in the appendix to further assist the health care staff in the nutritional care of the residents. Clinical Services contacts are listed after the table of contents. The Clinical Dietetics Staff at Laguna Honda Hospital may be contacted at 682-5776.~~

## ~~QUALITY OF CARE FOR THE ELDERLY~~

~~Many residents entering Laguna Honda have a history of poor nutritional intake because of lack of financial resources, inability to prepare or consume a balanced meal or a recent acute illness or injury. Proper nutrition through medical nutrition therapy is a vital factor in their convalescence. The person may improve physically, and often mentally, with a better diet. The registered dietitian plays an active, dynamic role in health maintenance and disease prevention to promote high quality nutrition care that provides positive benefits to the residents.~~

## ~~NUTRIENT RECOMMENDATIONS OF THE ELDERLY~~

The patient menu was developed in accordance with the most current Recommended Dietary Allowances (RDAs) and Daily Reference Intakes (DRIs) established by the Nutrition Research Council - National Academy of Sciences (Appendix 1). When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team work to individualize nutrition care of the patient considering their food preferences.

## LAGUNA HONDA 28-DAY MENU CYCLE DIET ANALYSIS

The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals and vitamins. Totals, averages and standard deviations were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting 759-4589.

## NUTRIENT NEEDS OF THE ELDERLY

### KILOCALORIES

Calorie needs per day are calculated individually for each resident by the RD. The Harris Benedict Equation can be used to calculate a resident's BEE requirement. Stress and activity factors are determined by the RD based on resident's medical condition and mobility. The determined stress and activity factor is multiplied by the resident's BEE to obtain total calories per day needed by the resident. If residents are obese (BMI>=30.0kg/m2; IBW>=130%) or underweight (BMI<=18.5kg/m2) calories may be adjusted by the RD for weight loss or gain during an appropriate timeframe. Residents with pressure ulcers require increased calories per day for wound healing.

### PROTEIN

Protein (grams) is calculated based on the residents' weight (kilograms) and medical condition. The minimum protein requirement is 0.8-1 gram of protein/ kilogram of body weight. Appendix 1.A. provides protein RDAs for healthy, older adults. If the resident is stable with normal weight (BMI: 19-24.9kg/m2) or overweight (BMI:25-29.9kg/m2) status, the actual weight (kg) may be used to determine protein needs. If the resident is obese (BMI>=30.0kg/m2), actual body weight (kg) may be used to determine appropriate protein needs. Residents, with pressure ulcers, require increased protein needs for wound healing.

### CARBOHYDRATE

The diets at Laguna Honda are designed with ~45-65% of total calories coming from carbohydrates. Carbohydrate restrictions, either for weight loss and/or blood glucose control, are determined by the RD and medical team depending on the residents' medical condition. Appendix 1-A. provides the RDA for carbohydrates for healthy, older adults.

### FAT

Fat intake should be adequate to provide for appetizing meals and satiety. At Laguna Honda, the food service and nutrition department strive to develop diets that meet the goal: ~30% of total kilocalories coming from fat, 10% of calories from saturated fats, less than 300 mg of dietary cholesterol and no trans-fat.

### VITAMINS AND MINERALS

Appendix 1.A., B. and C. provides Mineral and Vitamin RDAs for healthy, older adults.

~~FLUIDS AND DIETARY FIBER~~

~~Appendix 1.A. provides AI for total fiber and fluids for healthy, older adults.~~

# REGULAR DIET

## I. PURPOSE

The regular diet is designed to achieve or maintain optimal nutritional status in persons who do not require a therapeutic diet. Offers choices that promote intake of whole grains, fresh fruits, and vegetables, soups, fish and poultry, red meat and milk. However, there are no restrictions and individual preferences may necessitate the exclusion of certain food items.

## II. INDICATIONS

The regular diet is used to promote health and reduce the risks for the development of major, chronic and nutrition-related diseases.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix ~~Appendix~~ Table 1~~Table 1~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1800-2750 | 85-120 | 240-290 | 95-115 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or Salad w/ Dressing
3 oz. Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

## Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. General, Healthful Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=6. Accessed July 6~~29~~, 20~~18~~23

## TEXTURE MODIFIED DIETS

Dysphagia is the impaired ability to swallow.

Diagnoses that may be indicative of potential swallowing problems include any resulting in neurological impairment, head and neck cancer or surgery, patients with tracheostomy, vocal cord dysfunction, aspiration pneumonia, and dementia.

A dysphagia diet or diet texture modification may reduce the risk of aspiration. -Speech Language Pathologists (SLP) evaluate for swallowing deficits and recommend the least restrictive diet. The SLP works with the dietitian to optimize food variety while meeting the resident's nutritional and safety needs.

Signs to look for which may indicate possible dysphagia include:

- Coughing
- Choking
- Holding food in mouth
- Significant pocketing of food
- Significantly delayed swallow
- Significant leakage of food or liquid form the mouth
- Food or liquid coming from a tracheostomy (Serious sign of aspiration!)
- Excessive drooling
- Recurrent pneumonias

**Note:** Some persons with dysphagia can aspirate silently without exhibiting any of the above signs.

Dietary considerations for dysphagia:

1. Avoid small pieces of food for residents with reduced sensations as they can become lost in the mouth and increase the chance of choking.
2. Select foods that form a bolus within the mouth and do not break apart (e.g., bananas, mashed potatoes, macaroni and cheese).
3. Avoid sticky foods that adhere to the roof of the mouth. These can cause fatigue in residents with muscle weakness and risk of airway obstruction.
4. Thickening of thin liquids may be tried with select pureed foods.
5. Residents with decreased salivation need moist foods. Gravies, extra margarine, sauces, salad dressing may be used. Dry foods may be dunked in soup or beverage.
6. Avoid milk products if excess mucus formation is a problem as they increase salivation.
7. Individualize diets for consistency.
8. High calorie, high protein foods should be emphasized for dysphagia residents managing limited intakes at a time.
9. Offer small frequent meals when minimizing fatigue and optimizing food temperature and total nutrient intake is desirable.
10. Residents requiring thickened liquids are at increased risk for dehydration. -Thickened water and thickened juice should be offered several times a day between meals.

# DENTAL SOFT DIET

## I. PURPOSE

This diet provides soft-textured foods that can be easily chewed, requiring minimal biting. Foods are moist, easily crumbled, or served with ~~suace~~sauce or gravy to increase moisture ~~.includes soft textured foods while most raw foods are excluded. Regular foods are selected from all food groups to increase the acceptability of the diet.~~

## II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing solid foods because of missing teeth, poorly fitting dentures, and mouth pain. The diet is not intended for residents who have identified choking or swallowing problems.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 2300-2500 | 100-110 | 250-275 | 95-105 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Low Fat Milk
1 Serving Dessert
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or 6 oz. Soft Salad
3 oz. Meat or Chopped Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Slice White or Wheat Bread
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

**DENTAL SOFT DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk | Milk, buttermilk, milkshakes, plain or fruited yogurt. | Yogurt with nuts. |
| Meats, Fish, Poultry, | Tender or chopped meats and poultry, baked, boiled, steamed meat or chicken, such as ground beef, hot dog, cold cuts, Thinly sliced deli meats, ham, beef, turkey. Soft sandwich mixes, chicken nuggets. Baked, steamed or sauté fish & shrimp. | Crispy fried or breaded meats, fish and poultry. Thick sliced roasts or ham. Dry salami. |
| Cheese | Soft meat or cheese casseroles. Cottage cheese, soft cheeses. | Hard cheese. |
| Eggs | Soft scrambled eggs, soft cooked egg, poached egg, fried egg, plain egg salad. | None. |
| Vegetables | Soft, cooked vegetables. Sliced tomato, leaf lettuce. Tomato juice. | Kernel corn. Other raw vegetables. Crunchy vegetables. |
| Fruits | Canned fruit. Soft fresh fruit: melon, strawberries, ripe banana, grapes, orange and grapefruit sections. Stewed prunes, raisins. Fruit juices. | All other raw fruit, fruit that contains pits, seeds, and skin. Other dried fruit. |
| Starches | Soft potatoes or yams, cream corn, rice, noodles. French fries. | Whole kernel corn. Crunchy noodles. |
| Cereals | Hot cereals. Cold flaked cereal. | All coarse cold cereals and those with nuts or dried fruits. |
| Breads | White, wheat or rye- bread. Pancakes, waffles, French toast. Cornbread, soft rolls, sweet muffins, crumpets. | All breads that contain nuts. English muffin. |
| Fats and Oils | Margarine, butter, strained gravy, creamers, sour cream, mayonnaise, salad dressings. Crisp bacon and sausage links. | None. |
| Soups | Soups made with allowed foods. | All other soups. |

**DENTAL SOFT DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Beverages | Coffee, tea, sodas, milk.<br>Liquid nourishment supplements. | None. |
| Desserts | Ice cream, sherbet, smooth puddings, ~~jell~~gelatin~~o~~, custard.<br>Plain pies, cakes, cookies. | All desserts which contain fibrous fruits and nuts. |
| Miscellaneous | Sugar, jelly, syrup, honey.<br>Salt, spices. Hard candy. | Hard to chew snacks.<br>Chewy candy.<br>Pretzels |

# MECHANICAL SOFT DIET

## I. PURPOSE

This diet is designed to minimize the amount of chewing necessary to safely swallow food by residents.

## II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing or swallowing solid foods because of facial paralysis, poor or broken teeth, missing or poorly fitting dentures.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix- Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1700-2600 | 80-110 | 200-300 | 60-125 |

## V. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit or Juice | 6 oz. Soup or 6 oz. Soft Salad |
| 1 Serving Cereal | 3 oz. Chopped Meat or Alternate |
| 1 Egg or Alternate | 2 oz. Gravy |
| 1 Slice Toast or Alternate | 3 oz. Starch |
| 1 Pat Butter / Margarine | 3 oz. Cooked Vegetable |
| 8 oz. Low Fat Milk | 1 Slice White or Wheat Bread |
| Coffee, Tea, Decaf | 1 Pat Butter / Margarine |
| Sugar, Salt, Pepper | 1 Serving Dessert |
| | 8 oz. Low Fat Milk |
| | Coffee, Tea, Decaf |
| Whole grain breads, cereals and starches are served daily. | Sugar, Salt, Pepper |

The mechanical soft diet can be reduced in texture as necessary to meet the resident's needs. These adjustments may include:
~~One of the more common adjustments is the~~ *mechanical soft with puree vegetables* *and mechanical soft with puree fruits and vegetables* ~~*diet*~~. This provides the resident with soft foods without all foods having to be pureed. The diet may also be partially upgraded in texture to regular with mechanical soft entrée.

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. ~~National Dysphagia Diet Mechanically Altered~~IDDSI Level 5 Minced and Moist (Orange) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=420. Accessed July ~~28~~6, 2023~~18~~.

**MECHANICAL SOFT DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk | All milk: buttermilk, milkshakes, plain or fruited yogurt. Ice cream. | Yogurt with nuts. Ice cream with nuts. |
| Meats, Fish, Poultry, Cheese | Chopped meats, and poultry. Baked or tender grilled fish. Soft meat, fish or cheese casseroles, quiche, eggs. Cottage cheese, soft cheese. Smooth peanut butter. | All whole meats, poultry, fried fish, stringy meats. Hot dogs, hamburgers. Crunchy fried foods. Luncheon meats. Hard or strong cheeses. Crunchy peanut butter. |
| Eggs | Soft scrambled eggs, soft cooked, poached, fried egg. Plain egg salad. | |
| Vegetables | Tender cooked or pureed vegetables. Tomato Juice. Asparagus tips, F.C. beans. | Cut green beans, peas, corn, leafy greens. Fibrous, tough vegetables, Brussel sprouts, broccoli, raw vegetables. |
| Fruits | Soft canned fruit, ripe banana. Fruit juices. | All other raw fruit or fruit containing pits, seeds, skin. |
| Starches | Soft potatoes or yams, Juk. Cream corn, rice, noodles. Spaghetti, macaroni, other pastas. | Kernel corn. Snack chips. Crunchy fried foods. Snack crackers. |
| Cereals and Breads | Hot cooked cereals. Cold flaked or puffed cereal. White, wheat or rye bread. Pancakes, waffles, French toast, plain muffins, soft rolls. | All coarse cold cereals and breads that contain nuts, dried fruit, seeds, Crisp snacks, pretzels. Popcorn. |
| Fats and Oils | Margarine, butter, strained gravy, sauces, sour cream, cream, mayonnaise, mild salad dressings. | Crisp bacon, ham patty, sausage links and other breakfast meats. |
| Soups | Soups made with allowed foods and salt, mild herbs, spices and seasonings. | All other soups. |
| Beverages | Coffee, tea, sodas, milk. Liquid nourishment supplements. | None. |
| Desserts | Ice cream, sherbet, jello, smooth puddings, plain pies, cakes, sugar, jelly, syrup, honey. | All desserts containing nuts and fibrous fruits. Hard to chew snacks, chewy candy. Dried fruit. Cookies |

# SEMI-PUREE DIET

## I. PURPOSE

The Semi-Puree Diet contains food which has a smooth consistency to facilitate ease of chewing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs.

The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident. In addition to pureed foods, the following foods are allowed:- plain breads, muffins and pancakes, baked desserts, such as cakes, ripe banana, prepared eggs and soft sandwich mixes, cottage cheese, soft cheeses and fruit yogurt.

## II. INDICATIONS

This diet is designed for residents who are unable to chew or swallow solid foods due to: poor or broken teeth, missing or poorly fitting dentures, sore gums, or decreased mentation that interferes with eating. Food consistency is based on resident clinical condition and individual tolerance.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1600-3000 | 70-140 | 180-380 | 60-125 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cooked Cereal
1 Egg or Alternate
1 Slice Bread
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Strained Soup
4 oz. Pureed Meat or Alternate w/Gravy
3 oz. Mashed Potato or Alternate
3 oz. Pureed Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served as tolerated.

## Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 4 Pureed (Green) ~~National Dysphagia Diet Pureed~~ Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July ~~29~~6, 20~~18~~23.

**SEMI-PUREE DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | DO NOT SERVE |
|---|---|---|
| Milk and Dairy | Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream. | Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin. |
| Meats, Fish, Poultry | Meat, poultry and fish which are smooth pureed consistency. Soft sandwich mixes made from tuna, egg, chicken with mayonnaise. | All regular meats, fish and poultry if not pureed. Hard cheeses. Casseroles made w/ whole meats or vegetables. |
| Cheese | Cottage cheese, soft cheeses. | |
| Eggs | Eggs, soft boiled, scrambled. Plain egg salad with mayonnaise. | Lunchmeats, All other eggs. |
| Vegetables | Vegetables which are pureed consistency, tomato juice. | Whole or fresh vegetables unless blended till smooth. |
| Fruits | All fruit that is finely pureed. Applesauce, fruit juices, nectars thickened juices, ripe banana. | All other whole, canned or fresh fruit. Coconut. |
| Starches | Smooth mashed potatoes or yams, Smooth polenta, cream of rice, corn puree, pasta puree. Juk. | All other potatoes, rice or noodles. Kernel corn, French fries. |
| Breads, Cereals, Grains | Hot smooth cooked cereals, e.g. cream of wheat, farina, malt-o-meal. Plain Rice Porridge, Oatmeal Plain muffins, pancakes~~,~~. White, wheat bread or soft rolls. Soft cakes | All hard breads, crackers, and those containing seeds, nuts or dried fruit. Waffles, French toast. Cold cereal, pizza, tortillas. |
| Fats and Oils | Margarine, sour cream, mayonnaise, strained gravies. | All fried foods. Avocado. Chunky sauces, tartar sauce. |
| Soups | Thickened strained cream soups, Strained broth soups. | Chunky soups containing foods to avoid. |
| Beverages | Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements | None. |
| Desserts | Soft baked products, cake. Custard, smooth puddings, jello, ice cream and sherbet~~,~~. | Cookies, candy, jam, peanut butter. Baked products containing whole fruits, nuts, seeds. Doughnuts and pastries. |
| Miscellaneous | Sugar, salt, mild seasonings | Sticky /chewy food. Snack chips, pretzels, popcorn. |

# FULL PUREE DIET

## I. PURPOSE

The Full Puree Diet contains food that has a smooth consistency to facilitate ease of swallowing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs.

## II. INDICATIONS

The Full Puree diet is designed to facilitate eating for residents who are unable to chew, have difficulty swallowing or who may have other problems identified with feeding.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1920-2200 | 65-85 | 280-300 | 60-70 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit Juice
6 oz. Refined Hot Cereal
1 Serving ~~Nx Liquid~~Pureed Eggs
1 Serving Custard
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Half & Half
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Strained Soup/4 oz. Juice
4 oz. Puree Meat/Alternate
3 oz. Puree Starch/Gravy
3 oz. Puree Vegetable
1 Pat Butter / Margarine
4 oz. Puree Fruit/Dessert
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. ~~National Dysphagia Diet Pureed~~ IDDSI Level 4 Pureed (Green) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July ~~29~~6, 20~~18~~23.

**FULL PUREE DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | DO NOT SERVE |
|---|---|---|
| Milk and Dairy | Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream. | Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin. |
| Meats, Fish, Poultry, Cheese | Meat, poultry and fish which are smooth pureed consistency | All regular meats, fish and poultry if not pureed. Cheese. |
| Eggs ~~E~~eggs ~~(~~, ~~-~~boiled, scrambled, fried.~~)~~ | Custard. Pureed scrambled eggs. | All regular Lunchmeats. |
| Vegetables | Vegetables which are pureed consistency, tomato juice | Whole or fresh vegetables unless blenderized |
| Fruits | All fruit that is finely pureed. Applesauce, fruit nectars, thickened juices. | All other whole, canned or fresh fruit and juices. Banana. Coconut. |
| Starches | Smooth mashed potatoes or yams, smooth polenta, cream of -rice. | All other potatoes, rice or noodles. |
| Breads, Cereals, Grains | Hot smooth cooked cereals, cream of wheat, farina, malt-o-meal, cream of rice, Plain Rice Porridge, Oatmeal | **All breads,** coarse grains, oatmeal, cornmeal, rolled wheat. All crackers. Pancakes, waffles, tortillas. Cold cereal. |
| Fats and Oils | Margarine, sour cream, mayonnaise, strained gravies. | All fried foods. Avocado. Chunky sauces. |
| Soup | Thickened strained cream soups. Strained broth soups. | Chunky soups containing foods to avoid. |
| Beverages | Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements. | None. |
| Desserts | Smooth puddings, custard, jello, plain ice cream and sherbet. | All baked products, including pies, cakes, cookies, pastry, nuts, dried fruit, jam. |
| Miscellaneous | Sugar, clear jelly, salt, mild spices. | Candy, peanut butter. Pizza, popcorn, chips. Sticky or chewy food. |

## DYSPHAGIA DIET TEXTURE MODIFIED DI

Dysphagia is the impaired ability to swallow.

Diagnoses that may be indicative of potential swallowing problems include any resulting in neurological impairment, head and neck cancer or surgery, patients with tracheostomy, vocal cord dysfunction, aspiration pneumonia, and dementia.

A Dysphagia diet or diet texture modification may reduce the risk of aspiration. Speech Pathology evaluates for swallowing deficits and recommends the least restrictive diet texture with reduced risk of aspiration, working with the dietitian who optimizes food variety while meeting the resident's nutritional and safety needs.

Signs to look for which may indicate possible Ddysphagia include:

- Coughing
- Choking
- Holding food in mouth
- Significant pocketing of food
- Significantly delayed swallow
- Significant leakage of food or liquid form the mouth
- Food or liquid coming from a tracheostomy (Serious sign of aspiration!)
- Excessive drooling
- Recurrent pneumonias

**Note:** Some persons with Dysphagia can aspirate silently without exhibiting any of the above signs.

Dietary cConsiderations for Dysphagia:

1. Avoid small pieces of food for residents with reduced sensations as they can become lost in the mouth, and increase the chance of choking.
2. Select foods that form a bolus within the mouth and do not break apart (e.g., bananas, mashed potatoes, macaroni and cheese).
3. Avoid sticky foods that adhere to the roof of the mouth. These can cause fatigue in residents with muscle weakness and risk of airway obstruction.
4. Thickening of thin liquids may be tried with select pureed foods.
5. Residents with decreased salivation need moist, well lubricated foods. Gravies, extra margarine, sauces, salad dressing may be used. Dry foods may be dunked in soup or beverage.
6. Avoid milk products if excess mucus formation is a problem as they increase salivation.
7. Individualize diets for consistency.
8. High calorie, high protein foods should be emphasized for dysphagia residents managing limited intakes at a time.
9. Offer small frequent meals when minimizing fatigue and optimizing food temperature and total nutrient intake is desirable.
10. Residents requiring thickened liquids are at increased risk for dehydration. Thickened water and thickened juice should be offered several times a day between meals.

# DYSPHAGIA DIET

## I. PURPOSE

The Dysphagia diet is designed to help reduce the risk of aspiration by providing foods that facilitate swallowing. Food texture is a smooth puree consistency. Thin liquids are eliminated. Depending on the resident's individualized needs, liquids are served in either a nectar or a honey consistency.

## II. INDICATIONS

A swallowing evaluation is required to assess the cause of the Dysphagia and the underlying functional problem. The Speech Therapist can then provide advice on the most effective food textures and liquid consistency for the resident.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1). Residents with Dysphagia may have difficulty consuming adequate food volume and the diet may require nutritional supplements.

## IV. APPROXIMATE COMPOSITION:

| Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|
| Range | 2000 - 2200 | 81-90 | 235-289 |
| | 75-90 | | |
| Percent of Calories | | 15-17 % | 46-54 % |
| | 31-37 % | | |

## V. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Thickened Juice | 6 oz. Strained Cream Soup or |
| 6 oz. Refined Cooked Cereal | 4 oz. Thickened Juice or Gelatin |
| 4 oz. Custard or Pudding | 4 oz. Meat, Fish, Poultry Puree |
| 1 Pat Butter / Margarine | 3 oz. Mashed Potatoes or Starch |
| 8 oz. Thickened Milk | 2 oz. Gravy |
| Condiments | 3 oz. Vegetable Puree |
| 1 Pat Butter / Margarine | |
| 4 oz. Fruit Puree | |
| 8 oz. Thickened Milk | |
| Condiments | |

Whole grain breads, cereals and starches are served as tolerated.

## DYSPHAGIA DIET

### VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | DO NOT SERVE |
|---|---|---|
| Milk and Dairy | Custard, smooth yogurt, ice cream Milkshakes. Nectar and Honey consistency milk. | Thin milk beverages. * Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin. Buttermilk |
| Meats, Fish, Poultry, Cheese | Meat, poultry and fish which are pureed consistency. | All regular meats, fish, and poultry if not pureed. Cheese. |
| Eggs | Custard. | Eggs, boiled, scrambled. All other eggs. |
| Vegetables | Vegetables which are pureed consistency, tomato juice. | Whole or fresh vegetables unless blend till smooth. |
| Fruits | All fruit that is pureed. Applesauce, nectars and Thickened juices. | All other whole, canned. or fresh fruit. Thin juices. Banana. Coconut. |
| Starches | Smooth mashed potatoes, or smooth polenta, cream of rice. | All other potatoes, rice noodles. |
| Breads, Cereals, and Grains | Hot smooth cooked cereals, cream of wheat, farina, malt-o-meal | All breads. Tortillas. Oatmeal rolled wheat. |
| Fats and Oils | Margarine, cream, mayonnaise, Strained gravies. | All fried foods. Avocado. |
| Soups | Thickened strained cream soups. | Thin broth or chunky soups. |
| Beverages | Thickened liquids: juices, milk, water. Thick milkshakes, buttermilk. Thickened liquid supplements. | Coffee, tea, sodas. Regular water and milk. All thin liquids. |
| Desserts | Smooth puddings, custard Frozen ice cream and sherbet. | All baked products, pies cookies, cakes, pastry. Fruit ices (Sorbet). |
| Miscellaneous | Sugar, clear jelly, salt, mild spices. | Candy, jam, peanut butter. Snack chips, popcorn, pizza. Sticky or chewy food. |

# CLEAR LIQUID

## I. PURPOSE

This temporary, transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. It supplies fluid, electrolytes and energy in a form that requires minimal digestion. This diet consists of clear fluid or foods which are fluid at body temperature.

## II. INDICATIONS

This diet is designed to provide fluids and calories to prevent dehydration in residents who have diarrhea and or vomiting. This diet is also used for test diets requiring a clear G.I. tract.

## III. ADEQUACY

This diet does not meet the Recommended Daily Allowances for any nutrient. If residents are on this diet for more than three days, the rationale for the diet should be reviewed and revised, if necessary.

## VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | DO NOT SERVE |
|---|---|---|
| Clear Liquid Foods | | |
| Soups | Clear broth or bouillon | All Others |
| Sweets and Desserts | Clear, flavored gelatin, Clear fruit ices/popsicles, sugar, honey, hard candy, sugar substitutes. | All Others |
| Beverages | Clear fruit juices, such as apple, cranberry, or grape juice.<br><br>Clear coffee or tea and carbonated beverages, as allowed and tolerated. | All Others including nectars, milk, cream, juices with pulp. |
| Miscellaneous | High caloric clear supplement beverages | All Others |

# FULL LIQUID DIET

## I. PURPOSE

This diet consists of a variety of foods that are liquid or very soft in texture. In addition, supplements such as liquid nutritional formula products are served. The primary foods allowed on this diet are strained soup, custard, gelatin~~jello,~~ juice, milk, pudding and ice cream.

## II. INDICATIONS

This diet is designed for residents who are unable to chew due to recent dental surgery or are unable to tolerate solid foods due to cancer of the mouth, throat, stomach, or G.I. tract. This diet may be used as the interim diet in weaning residents from enteral diets, when swallowing semi-soft solid foods is a problem. This diet should be progressed to normal food intake as tolerated. However, long term use of this diet may be warranted for quality of life and pleasure.

## III. ADEQUACY

The Full Liquid Diet is not nutritionally adequate and therefore should not be used for extended periods of time without consultation with the dietitian.

## I. APPROXIMATE COMPOSITION: (includes the use of supplements)

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1500-2000 | 65-90 | 240-355 | 30-75 |

## V. SUGGESTED MEAL PATTERNS:

BREAKFAST
8 oz. Juice
Refined Cereal
Low fat Milk
Coffee/Tea/Decaf

MID-MORNING NOURISHMENT
8 oz. Nx Liquid
8 oz. Juice

LUNCH & DINNER
Strained Cream Soup
8 oz. Juice
5 oz. Fortified Pudding
8 oz. Nx Liquid
Low fat Milk
Coffee, Tea, Decaf

AFTERNOON NOURISHMENT
8 oz. Nx Liquid
5 oz. Fortified Pudding

EVENING NOURISHMENT
8 oz. Juice
8 oz. Nx Liquid
or 8 oz. Milk
5 oz. Nx Pudding

# THICKENED LIQUIDS

## I. PURPOSE

Thickened liquids are recommended for people with swallowing difficulty. Consuming thickened liquids will decease aspiration risk.~~risk of choking or coughing on liquids.~~ Laguna Honda Hospital currently supplies thin, nectar, and ~~or~~ honey thick liquids. Honey thick is the thickest consistency << Nectar thick is an upgraded liquid consistency << thin liquids (no diet order required, automatically supplied on tray with any diet order without liquid consistency specially ordered by MD). Liquid consistency may be ordered with a swallow evaluation recommendation, MD/RD/Nursing observation or resident preference for quality of life.

## II. INDICATIONS

Dysphagia, difficulty swallowing, head/throat/esophageal cancer, radiation therapy, cognitive impairment, thin liquids are observed not to be tolerated by speech therapist, RD, nursing staff, MD, resident or family member

## III. ADEQUACY

This diet is a modifier to any diet.

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1800-2750 | 85-120 | 240-290 | 95-115 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Honey or Nectar Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Honey or Nectar Low Fat Milk
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Nectar Thick Soup or Salad w/ Dressing
3 oz. Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Margarine
8 oz. Honey or Nectar Low Fat Milk
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

## VI. LIQUID FOOD GUIDE

All puree and strain soups may be ordered w/specialized feeding plan and/or MD order for quality of life and can be thickened with honey or nectar thick packets using manufacturer's instructions.

Beverages such as milk, juices without pulp, coffee, tea, soda, carbonated beverages, alcoholic beverages, eggnog and nutritional supplements should be thickened to the right thickness as ordered by MD.

Frozen beverages such as malts and milk shakes should be avoided.

**THICKENED LIQUIDS**

VI. LIQUID FOOD GUIDE

Sherbet, frozen yogurt, and ice cream should be avoided.

Gelatin should also be avoided.

Yogurt is acceptable for honey and nectar thick liquid consistency

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Thickened Liquid Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=424. Accessed July ~~29~~6, 20~~18~~23

# FLUID RESTRICTION

## I. PURPOSE

This is a diet modifier designed to prevent fluid retention. It can be added to any diet order and specifies the daily fluid allowance in milliliters (mL) as 1000 mL, 1200 mL, 1500mL and 1800~~2000~~ mL. The amount of fluids delivered on the tray will equate to half of the daily allowance or as adjusted by RD for quality life. This allows one half of fluids to be administered by nursing for medication administration and floor stock fluid requests.

## II. INDICATIONS

Residents with the following diagnosis may have a fluid restriction ordered by the MD: heart failure, renal dialysis disease, hepatic disease, hypervolemia; hyponatremia.

## III. ADEQUACY

~~Based on diet order that this modifier is added to~~Fluid adequacy is based on the ~~.~~physician order.

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1800-2750 | 85-120 | 240-290 | 95-115 |

## V. FLUID RESTRICITON MEAL PATTERN:

BREAKFAST
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Sugar, Salt, Pepper

LUNCH & DINNER
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Margarine
Sugar, Salt, Pepper

4 oz. fruit, 8 oz. Skim Milk and/or 6 oz. Coffee,
Total fluid no more than 8 oz. at Breakfast, Lunch and/or Dinner
Total daily dietary fluid no more than 24 oz. (720 mL)

| Restriction | Breakfast | Lunch | Dinner | Total Dietary |
|---|---|---|---|---|
| 1800 mL | 240 mL | 240 mL | 240 mL | 720 mL |
| 1500 mL | 240 mL | 240 mL | 240 mL | 720 mL |
| 1200 mL | 240 mL | 120 mL | 240 mL | 600 mL |
| 1000 mL | 240 mL | 120 mL | 120 mL | 500 mL |

*Additional fluid can be added if total fluid delivered by dietary within 1000 mL

## FLUID RESTRICTION

VI. FLUID AND CONTENT OF SELECTED FOODS

| Food Item | Fluid (mL) | Food Item | Fluid (mL) |
|---|---|---|---|
| Broth (6 oz.) | 180 | Ice Cream | 120 |
| Hot Cocoa (7 oz.) | 210 | ~~Jell-O~~Gelatin | 120 |
| Coffee/Tea (6 oz.) | 180 | Milk (8 oz.) | 240 |
| Creamer | 15 | Soup (6 oz.) | 180 |
| Fruit Ice (4 oz.) | 120 | Ensure Clear (8 oz.) | 240 |
| Fruit Juice (4 oz.) | 120 | Ensure Van, Choc, Straw (8 oz.) | 240 |
| Sherbet (4 oz.) | 120 | Ensure Enlive (8 oz.) | 240 |

Supplements:
Fluids provided from supplements should be accounted for in the fluid restriction

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. Fluid-Restricted Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=413. Accessed July ~~29~~6, 20~~18~~23.

# ~~DIABETIC~~CONSISTENT CARBOHYDRATE DIETS

## I. PURPOSE

The goals of nutritional therapy and diabetes management for all people are:

- to improve blood glucose and lipid levels
- to promote consistent day-to-day intake for people with insulin-dependent diabetes
- weight management for people with non-insulin-dependent diabetes
- to encourage healthy eating habits for residents during their stay at LHH, for residents with diabetes and for those with coexisting medical conditions.

~~Diabetic~~ The consistent carbohydrate diets are based on ~~the~~recommendations from the Academy of Nutrition and Dietetics, which recommends consistent carbohydrate intake at snacks and meal on a day-to-day basis for improved glycemic control. The diet provides consistent levels of carbohydrate at each meal. There are three levels available: 60g, 75g and 90g of carbohydrates per meal. ~~American Diabetic Association (ADA) and the Academy of Nutrition and Dietetics' Exchange Lists for Meal Planning where foods are classified by similar nutrient composition. 1 Exchange of Carbohydrates equals to 15 grams carbohydrates.~~

Consistency in meal schedules and portion sizes assist in normalizing blood sugar. Protein, fat and carbohydrate are divided throughout the day; ~~concentrated~~ foods high in added sugars are avoided.

Institutional menus are carefully planned and served to accommodate a resident's preferences. The dietitian adjusts ~~in~~ dietary patterns~~, using the diabetic exchange system,~~ for individual preferences and tolerances, to maximize compliance with dietary restrictions and consistency in carbohydrates. A variance of +- 15g of carbohydrate is allotted per meal to allow for variety and adequacy in the diet. ~~Therefore, daily meal intake will provide approximately the ADA guidelines for distribution of calories.~~

Morning, afternoon or evening nourishments, composed of both protein and carbohydrate, may be planned when necessary or by request.

## II. INDICATIONS:

Diabetes mellitus or altered glucose tolerance.

## III. ADEQUACY

Diets of at least 1500 calories are nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION

See individual dietary patterns by ~~caloric value~~carbohydrate level in section VII.

## ~~DIABETIC~~CONSISTENT CARBOHYDRATE DIETS

V. FOODS TO AVOID:

Condiments: Sugar, honey, jam, jelly, molasses, maple syrup, corn syrup

Breakfast Foods: Sweetened or sugar-coated cereals, doughnuts, sweet rolls.

Fruits: Dried fruit, frozen or canned fruit with added sugar or syrup.

Beverages**: S**weetened sodas or other beverages containing sugar.

Desserts: Cakes, pies, cookies, ice cream, jello, pudding.

Snacks: Candy, milkshakes, snack chips and snack crackers.

VI. FOODS CONSIDERED ACCEPTABLE IN UNLIMITED AMOUNTS

Sugar substitutes
Coffee, tea, Decaf
Unsweetened Gelatin
Vinegar
Spices and Herbs
Mustard
~~Dietetic Catsup~~
Fat Free broth
Bouillon
Consommé
Unsweetened Cranberries
Unsweetened Lemons and Limes
Unsweetened Pickles
Raw Vegetables
Horseradish
Lettuce
Sugar Free Beverages
Cucumber
Radish
~~P~~Parsley

## ~~DIABETIC~~CONSISTENT CARBOHYDRATE DIETS

VII. MEAL PATTERN BY ~~EXCHANGES~~ CARBOHYDRATE LEVEL

| Carbohydrate Level | 60g | 75g | 90g |
|---|---|---|---|
| Calories: | 1600 | 1800 | 2000 |
| % Protein: | 22% | 22% | 21% |
| % Carbohydrate: | 45% | 50% | 54% |
| % Fat: | 33% | 28% | 25% |
| ~~Calories:~~ | ~~1500~~ | ~~1600~~ | ~~1800~~ |
| ~~% Protein~~ | ~~24~~ | ~~22~~ | ~~22~~ |
| ~~% Carbohydrate~~ | ~~40~~ | ~~41~~ | ~~45~~ |
| ~~% Fat~~ | ~~36~~ | ~~37~~ | ~~33~~ |

**Diabetic Exchange Groups~~*~~ Served at Meals for Each ~~Calorie~~ Carbohydrate Level**

| | **60g (4 CHO/meal)** | **75g (5 CHO/meal)** | **90g (6 CHO/meal)** |
|---|---|---|---|
| **Breakfast:** | | | |
| Fruit | 1 (15 g CHO) | 1 (15 g CHO) | 1 (15 g CHO) |
| Bread/Starch | 2 (15 g CHO) | 3 (15 g CHO) | 4 (15 g CHO) |
| Egg/Protein | 1 | 1 | 2 |
| Fat | 1 | 1 | 1 |
| Milk | 1 (12 g CHO) | 1 (12 g CHO) | 1 (12 g CHO) |
| Lunch/Dinner: | | | |
| Meat/Protein | 2 | 3 | 3 |
| Bread/Starch | 2 (15 g CHO) | 3 15 g CHO) | 4 (15 g CHO) |
| Vegetable | 1 | 1 | 1 |
| Fruit | 1 (15 g CHO) | 1 (15 g CHO) | 1 (15 g CHO) |
| Fat | 1 | 1 | 1 |
| Milk | 1 (12 g CHO) | 1 (12 g CHO) | 1 (12 g CHO) |

| ~~**Breakfast:**~~ | ~~**1500**~~ | ~~**1600**~~ | ~~**1800**~~ |
|---|---|---|---|
| ~~Fruit~~ | ~~1~~ | ~~2~~ | ~~1~~ |
| ~~Bread~~ | ~~2~~ | ~~2~~ | ~~3~~ |
| ~~Egg~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Fat~~ | ~~1~~ | ~~1~~ | ~~3~~ |
| ~~Low Fat Milk~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~**Lunch:**~~ | | | |
| ~~Meat~~ | ~~3~~ | ~~3~~ | ~~3~~ |
| ~~Bread~~ | ~~1~~ | ~~1~~ | ~~2~~ |
| ~~Vegetable~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Fruit~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Fat~~ | ~~0~~ | ~~1~~ | ~~1~~ |
| ~~Low Fat Milk~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~**Dinner:**~~ | | | |
| ~~Meat~~ | ~~3~~ | ~~3~~ | ~~3~~ |
| ~~Bread~~ | ~~1~~ | ~~1~~ | ~~2~~ |

| | | | |
|---|---|---|---|
| ~~Vegetable~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Fruit~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Fat~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| ~~Low Fat Milk~~ | ~~1~~ | ~~1~~ | ~~1~~ |
| | | | |
| ~~H.S. SNACK~~ | ~~0~~ | ~~0~~ | ~~0~~ |
| | | | |
| ~~Approximate Total Calories:~~ | ~~1532~~ | ~~1630~~ | ~~1810~~ |

*1 Exchange Group = 15 grams Carbohydrate

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. ~~Type 2 Diabetes Nutrition Therapy~~Carbohydrate Counting for People with Diabetes. ~~https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=48~~ https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=123.~~.~~ Accessed July 6~~29~~, 2023~~18~~

~~http://www.diabetes.org/food-and-fitness/food/what-can-i-eat/understanding-carbohydrates/carbohydrate-counting/carbohydrate-counting.html?loc=ff-slabnav.~~ https://diabetes.org/healthy-living/recipes-nutrition/understanding-carbs/carb-counting-and-diabetes. Accessed July ~~29~~6, 20~~18~~23

# NO CONCENTRATED SWEETS DIET

## I. PURPOSE

This diet limits foods containing concentrated forms of sucrose or glucose that may be absorbed quickly and cause rapid increases in blood sugar. This diet is appropriate for overweight individuals who require fewer calories than provided in a Regular Diet. Because of the complexity of obesity and the generally poor prognosis for weight loss, a No Concentrated Sweets Diet is preferred for maximal compliance. If this diet does not facilitate desired weight loss, a specific, individualized caloric restriction may be required.

## II. INDICATIONS

This diet is designed for residents with maturity-onset diabetes mellitus who do not require or are unable to follow a more structured diabetic diet using the Exchange List System. This diet can also be used for desirable weight management.

- See Diabetic Diet

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 2000-2250 | 95-110 | 200-250 | 90-100 |

## V. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit Juice | 6 oz. Soup or Salad with Dressing |
| 1 Serving Cereal | 3 oz. Meat or Alternate |
| 1 Egg or Alternate | 2 oz. Gravy |
| 1 Slice Toast | 3 oz. Starch |
| 1 Pat Butter / Margarine | 3 oz. Vegetable |
| 8 oz. Low Fat Milk | 1 Serving Calculated Dessert |
| Coffee, Tea, Decaf | 1 Slice Bread, 1 Pat Butter / Margarine |
| Sugar Sub., Salt, Pepper | 8 oz. Low Fat Milk |
| | Coffee, Tea, Decaf |
| | Sugar Sub., Salt, Pepper |

## NO CONCENTRATED SWEETS DIET

VI. FOODS TO BE AVOIDED:

Condiments: Sugar, honey, jam, jelly, marmalade, molasses, maple syrup, corn syrup.

Breakfast Foods: Sweetened or sugar coated cereals, doughnuts, sweet rolls, coffee cake.

Fruits: Frozen and canned fruit or juices with added sugar and syrups (High Fructose).

Desserts: Cakes, pies, cookies, ice cream, sherbet, pudding, jello, banana bread, pastries.

Beverages: Chocolate milk, carbonated or other beverages containing sugar.

Snacks: Candy, popsicles, milkshakes, chewing gum, potato chips, snack crackers. Snacks and desserts that are high in fat.

VII. FOODS TO BE USED AS DESIRED:

Beverages: Artificially sweetened lemonade, powdered fruit drinks or '0' calorie carbonated drinks, coffee, tea, coffee substitutes.

Foods: Unsweetened gelatin, dill or sour pickles, broth, consommé, bouillon, fresh unsweetened cranberries or rhubarb, low calorie salad dressings, unsweetened jelly, jam or syrup, sugarless gum.

Seasonings: Artificial sweetener, salt, pepper and other spices, herbs, mustard, vinegar; meat sauces; Extracts such as vanilla, butter, maple.

# RENAL DIET

## I. PURPOSE

The protein (60 gm.), sodium (2.0 gm.), potassium (2-3 gm.) and phosphorous (800-1000 mg.) controlled diet is designed to provide adequate amounts of essential nutrients and sufficient calories to maintain optimal nutritional status in those residents with impaired renal function. Modifications in the diet may be moderate or may require complex modification depending on the stage of kidney disease. Refer to individual sodium, potassium, phosphorous restricted diets for comprehensive information on food recommendations.

## II. INDICATIONS

This diet provides a guide for planning diets for persons with acute or chronic renal failure, and for residents on hemodialysis and peritoneal dialysis. The cause and the degree of kidney dysfunction should determine the level of protein, sodium, and potassium restriction in the diet.

Protein intake needs to be controlled to avoid excessive amounts of nitrogenous waste products in the blood and to prevent negative nitrogen balance.

Sodium content of the diet is controlled to help maintain normal hydration status, to avoid fluid retention, hypertension, and to help prevent congestive heart failure. Pyelonephritis and polycystic kidney diseases tend to be salt wasting conditions that require increased sodium.

Potassium content of the diet is controlled to prevent hyperkalemia, as well as hypokalemia in some instances. Consideration for the level of potassium in the diet includes checking serum potassium levels, urinary potassium level, and drug therapy (such as digoxin, furosemide, etc.). Stress, catabolism, and diabetic ketoacidosis can increase potassium levels.

## III. ADEQUACY

This diet is potentially ~~is~~ low in calories, minerals and vitamins. A nutrition supplement with low protein, high calories may be recommended to bring the calories, minerals and vitamins up to optimal. Calcium-based phosphate binders are often used with this patient population and should be taken into consideration when analyzing overall calcium intake.

## IV. APPROXIMATE COMPOSITION:

RENAL - 60 gm Protein, 2 gm Sodium, 2 - 3 gm Potassium, 800-1000 mg Phosphorous

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1500-2050 | 60-62 | 185-235 | 65-100 |

## V. SUGGESTED MEAL PATTERN:

RENAL - 60 Gram Protein, 2 Gram Sodium, 2 - 3 Gram Potassium, 800-1000 mg Phosphorous

BREAKFAST
4 oz. Fruit Juice (low potassium)
1 Serving Cereal - Half & Half
1 Slice Toast
1 Pat Margarine
1 Egg
8 oz. Low Fat Milk –Lunch **or** Dinner
Coffee, Tea, Decaf
Sugar, Pepper

LUNCH & DINNER
Salad w/Diet Dressing (Lunch)
1/2 Portion LS Entree (limited beans and processed meat)
1/2 Portion LS Starch
1/2 Portion LS Vegetable (low potassium)
1 Slice Bread - 1 Pat Margarine
1 Serving Fruit (low potassium)
8 oz. Low Fat Milk -Lunch or Dinner
4 oz. Nondairy Substitute (Lunch or Dinner)
Coffee, Tea, Decaf
Sugar, Pepper, Half & Half

**RENAL DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk and Milk Products | All in limited quantities within 8 fl. oz. restriction per day | Soy milk, malted milk. Excess of 8 fl. oz./ day of milk, chocolate milk, buttermilk, puddings, cream soups, light cheese, soy milk |
| Meats, Fish, Poultry | All except those excluded, tofu ok | Canned, cured, smoked, pickled, spiced or Processed meats, such as bacon, regular Sausage, luncheon meats, frozen dinners, Canned meats, dried peas, limit beans and lentils, avoid salted nuts |
| Meat Alternates | 1 egg daily, tofu ok | Beans |
| Vegetables | All those not high in potassium Vegetables included but not limited To green and wax beans, beets, Cabbage, carrots, cauliflower, celery Corn, cucumber, green peas, Summer Squash, turnips, peppers, onions, Asparagus, zucchini, greens (mustard, Collard) | All those high in potassium Canned vegetables, vegetables in brine, artichoke, potato, sweet potato, spinach, Brussel sprouts, chard, pumpkin, yams, okra tomato and tomato sauce |
| Fruits | All those not high in potassium Fruits included but not limited to apple, Blueberry, cranberry, fruit cocktail, grape Juice, grapes, peaches, pears, pineapple, Strawberry, watermelon | All those high in potassium Dried fruits, bananas, orange and juice, raisins, prunes and juice, avocado, apricots, Limit: cherries, cantaloupe, grapefruit, mango |
| Breads, Cereals | Most bread, cereals (1 cup), pasta, rice | Whole wheat breads, croissants, Sweet potatoes, potato chips, bran Avoid potatoes |
| Fats and Oils | Butter or margarine. All fats and oils, low salt gravy, mayo, Salad dressings | Bacon, cream sauces, sour cream |
| Soups | All except those not recommended | Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes. Butternut. |
| Beverages | Carbonated beverages other than cola, Coffee, tea, milk limited to 1 cup/day | Cola, cocoa, tomato/veg juice, canned soup, coconut water |
| Desserts | All except foods not recommended | Chocolate, nuts, cream/pumpkin pies, |
| Miscellaneous | Herbs and spices without added salt, all Except those listed in foods not Recommended | Salt, monosodium glutamate, olives, soy sauce, teriyaki sauce, barbeque sauce, ketchup, phosphorous containing ingredients (e.g. calcium phosphate, disodium phosphate, phosphoric acid, etc.) |

## RENAL DIET

### Reference

Nutrition Care Manual. Chronic Kidney Disease Stage ~~1 4~~3-5 Nutrition Therapy ~~https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=336.~~https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July ~~28~~6, 20~~18~~23

Nutrition Care Manual. Chronic Kidney Disease Stage 5 Tips for People Not on Dialysis Receiving Conservative, Supportive Or Medical Care Nutrition Therapy ~~https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157~~ https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=160. Accessed July ~~28~~6, 20~~18~~23

# POTASSIUM CONTROLLED DIET

3 gram potassium

## I. PURPOSE

The diet is designed to achieve and maintain normal potassium levels in individuals at risk for hyperkalemia. This diet also allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

## II. INDICATIONS

Elevated serum potassium and resident medical condition determine level of potassium restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: receiving Renal Dialysis, hyperkalemia, receiving potassium sparing medications and extensive tissue damage.

## III. ADEQUACY

This diet may not meet all the Recommended Dietary Allowances, therefore, supplements may be required. The 3 gram potassium level is recommended where moderate control is desired.

## IV. APPROXIMATE COMPOSITION:

| | Potassium | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|---|
| Range | 3 grams | 2000-2100 | 90-100 | 210-220 | 87-93 |

## V. SAMPLE MEAL PATTERN: 3 Gram Potassium

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Juice (low potassium) | 6 oz. Salad/Soup - Lunch **or** Dinner |
| 1 Serving Cereal | 3 oz. Meat or Alternate (limit intake of fish/bean/turkey) |
| 1 Egg | 3 oz. Rice or Noodles (avoid potatoes) |
| 1 Slice Toast | 3 oz. Vegetable (low potassium) |
| 1 Pat Margarine | 1 Serving Fruit Dessert (low potassium) |
| 8 oz. Low Fat Milk- Lunch **or** Dinner | 1 Slice Bread |
| Coffee, Tea | 1 Pat Margarine |
| Sugar, Pepper | 8 oz. Low Fat milk - Lunch **or** Dinner |
| | Coffee, Tea |
| | Sugar, Pepper |

Snacks included per patient preference and/or to meet nutrient needs.

## Reference

Academy of Nutrition Dietetics. Nutrition Care Manual. Chronic Kidney Disease Stages 3--5 Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July 286, 20182023

Academy of Nutrition and Dietetics. Nutrition Care Manual. Potassium Content of FoodsHigh Potassium Foods List. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=478. --Accessed July 286, 20182023

**POTASSIUM CONTROLLED DIET**

3 gram potassium

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk and Milk Products | All in limited quantities within 8 fl. oz. restriction per day | Soy milk, malted milk. Excess of 8 fl. oz. per day of milk, chocolate milk, buttermilk, yogurt, puddings, cream soups, Cheese, cottage cheese, custard, ice cream |
| Meats, Fish, Poultry | Meats; Fish except those not Recommended | Fish-halibut, tuna, cod, snapper, Turkey |
| Meat Alternates | 1 egg daily. | Beans |
| Vegetables | Beets (canned), Broccoli, Cabbage, Carrots, Cauliflower, Corn, Cucumber, Eggplant, Green Beans, Kale, Lettuce (1 cup), Mushrooms, Onions, Radishes, Snow Peas, Summer Squash, Turnips | Artichokes, Avocado, Brussel Sprouts, Butternut Squash, Greens (Mustard /Collard), Okra, Parsnips, Potato, Pumpkin Spinach, Sweet potatoes, Swiss Chard Tomatoes, Tomato Sauce/Puree/ Juice, Wax Beans, Winter Squash, Yam |
| Fruits | Apples, Applesauce, Blueberries Cranberry Fruit/Juice, Fruit Cocktail Grape Juice, Grapes, Lemon, Lemon Juice, Limes, Lime Juice, Peaches (canned), Pineapples, Plums (1), Strawberries, Tangerines (1), Watermelon | Pomegranate, Prune Juice, Prunes, Raisins |
| Breads, Cereals | White and Brown Rice, Tortilla, flour Or corn, Waffles, Bagels, English Muffin, Oatmeal, White Bread/Pasta | Bran Muffins, dark rye bread, gingerbread, granola, Avoid potatoes |
| Fats and Oils (Limit meat gravies) | Butter or margarine. All fats and oils. | Limit intake of nuts/seeds |
| Soups | All except those not recommended | Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes. Butternut. |
| Beverages | Cranberry juice, tea | Limit dairy intake, fruit/veg juices high in Potassium, soy milk |
| Desserts | Marshmallows, gelatin, ice pops | Desserts made with high amounts of dairy or high potassium veg/fruits |
| Miscellaneous | All except foods not recommended | Salt-Substitutes, chocolate, maple syrup, barbeque sauce, soy sauce, steak sauce, Worcestershire sauce |

# LOW PHOSPOROUS DIET

800-1000 MG PHOSPHOROUS

## I. PURPOSE

This diet is to achieve and maintain normal phosphorous levels in individuals at risk for elevated phosphorous levels in the blood. It is a modifier of the regular diet that excludes/limit foods high in phosphorous and limit phosphorous intake from meals to less than 1000 mg per day. This allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

## II. INDICATIONS:

Elevated serum phosphorous and resident medical condition determine level of phosphorous restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: Renal Dialysis disease, autoimmune activating mutations of the calcium-sensing receptor, parathyroid disease, Vitamin D or Vitamin A intoxication, granulomatous disease, immobilization, osteolytic metastases, milk-alkali syndrome and severe hypermagnesemia or hypomagnesemia.

## III. ADEQUACY:

This diet may not meet all the RDAS, therefore, supplements may be required. The 800–1000 gram phosphorous level is recommended where moderate control is desired.

## IV. APPROXIMATE COMPOSITION:

| | Phosphorous (mg.) | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|---|
| Range | 800-1000 | 2000-2100 | 90-100 | 210-220 | 87-93 |

## V. SAMPLE MEAL PATTERN: 800-100 mg Phosphorous

**BREAKFAST**
4 oz. Juice
1 Serving Cereal
1 Egg
1 Slice Toast
1 Pat Margarine
8 oz. Low Fat Milk (limited quality, no more than 1 cup/day)
Coffee, Tea (non-dairy creamer)
Sugar, Pepper

**LUNCH & DINNER**
6 oz. Soup - Lunch or Dinner
3 oz. Meat or Alternate (limit meat and legume)
3 oz. Rice or Noodles (avoid whole grains)
3 oz. Bland Vegetable
1 Serving Fruit Dessert
1 Slice Bread
1 Pat Margarine
8 oz. Low Fat Milk (limited quality, no more than 1 cup/day)
Coffee, Tea
Sugar, Pepper

Additional snacks may be added based on individual patient needs if total phosphorus intake within limit.

**LOW PHOSPHOROUS DIET**
800-1000 grams potassium

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk and Milk Products | Whole, lowfat or nonfat milk Cheese. Ice cream, sherbet. (8 oz. milk/day) | Commercial milk drinks, milkshakes. Cocoa, cream soups, cottage cheese, yogurt, puddings, custard, ice cream, buttermilk |
| Meats, Fish, Poultry | Limit meats | Organ meats (1 oz.), nuts (1/4 cup), |
| Meat Alternates | 1 egg daily | Tofu (1/4 cup), Vegetarian meat replacements |
| Vegetables | All, except peas | Peas |
| Fruits | All fresh or canned fruits and fruit juices | None |
| Breads, Cereals and Starches | Refined white grains, bread, pasta bagel (1/2 small); bread, all kinds (1 slice); dinner roll (1 ea); English Muffin (1/2) | Biscuits, muffin (1 small); granola/oatmeal (1/2 cup); pancakes/waffles (1 ea); whole wheat cereal, bran cereal (1/2 cup); tortillas, corn (2 ea); whole grain bread; brown rice |
| Fats and Oils | All fats and oils. | Limit intake of nut and nut butters |
| Soups | None. | Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes. |
| Beverages | All, except those not recommended | Chocolate drinks, cocoa, drinks made w/milk, canned iced teas, dark colas |
| Desserts | All, except those excluded. | Chocolate, caramels, desserts made primarily from diary products (cheesecake) |
| Miscellaneous | All, except those not recommended | Phosphorus-containing ingredients (e.g. calcium phosphate, disodium phosphate, Phosphoric acid, etc.) |

**Reference**

Nutrition Care Manual. Chronic Kidney Disease Stage 3-5 Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157 . Accessed July 286, 202318

Nutrition Care Manual. Phosphorous Content of Foods. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=477. Accessed July 6, 2023

# SODIUM CONTROLLED DIETS

## I. PURPOSE

The goal of sodium restriction is to help prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control.

## II. INDICATIONS:

Restriction of dietary sodium may decrease body fluid volume and relieve symptoms of diseases, e.g., congestive heart failure or other cardiovascular diseases, cirrhosis, hypertension, ascites, SIADH, other conditions that may cause fluid retention, hypernatremia or renal diseases where the kidneys cannot get rid of excess sodium and water. The physician should specify the level of sodium restriction desired using the following guide:

No Added Salt (3-5 grams sodium - 130-217 mEq)--mild sodium restriction
2 Gram Sodium (87 mEq)--moderate sodium restriction

For greater flexibility and resident compliance, it is preferred that the No Added Salt diet be ordered for residents not exhibiting acute disease symptoms. A salt-free herb and spice seasoning is served with meals.

## III. ADEQUACY;

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1~~A~~).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| 2 Gram Sodium (87 mEq)--moderate sodium restriction | | | | |
| Range | 1700-2500 | 75-115 | 180-270 | 50-115 |
| No Added Salt Diet (3-5 gram sodium - 130-217 mEq)--mild sodium restriction | | | | |
| Average | 1900-2400 | 90-100 | 200-240 | 75-90 |

## SODIUM RESTRICTED DIETS

V. SUGGESTED MEAL PATTERN:

2 Gram Sodium

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit or Juice | 6 oz. Low Sodium Soup or Salad w/Diet Dressing |
| 1 Serving Low Sodium Cereal | 3 oz. Low Sodium Meat or Alternate |
| 1 Serving Low Sodium Egg | 2 oz. Low Sodium Gravy |
| 1 Slice Toast | 3 oz. Low Sodium Starch |
| 1 Pat Butter / Margarine | 3 oz. Low Sodium Vegetable |
| 8 oz. Low Fat Milk | 1 Serving Dessert |
| Coffee, Tea, Decaf | 1 Sl. Bread - 1 Pat Butter / Margarine |
| Sugar, Pepper | 8 oz. Low Fat Milk LS herbs and spices |
| Coffee, Tea, Decaf | |
| | Sugar, Pepper, LS herbs and spices |

No Added Salt

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit or Juice | 6 oz. Low Sodium Soup or Salad w/Diet Dressing |
| 1 Serving Cereal | 3 oz. Meat or Alternate |
| 1 Serving Egg or Alternate | 2 oz. Gravy |
| 1 Slice Toast | 3 oz. Starch |
| 1 Pat Butter / Margarine | 3 oz. Cooked Vegetable |
| 8 oz. Low Fat Milk | 1 Serving Dessert |
| Coffee, Tea, Decaf | 1 Sl. Bread - 1 Pat Butter / Margarine |
| Sugar, Pepper | 8 oz. Low Fat Milk |
| LS herbs and spices | Coffee, Tea, Decaf |
| | Sugar, Pepper, LS herbs and spices |

Whole grain breads, cereals and starches are served daily.

## SODIUM-CONTROLLED DIETS

VI. FOODS TO BE AVOIDED:

| FOOD GROUP | 2 Gram Sodium | No Added Salt |
|---|---|---|
| Milk | More than 3 cups/ day Buttermilk, milkshake. | More than 3 cups per day, Buttermilk |
| Meat, Fish, Poultry/ Eggs/ Cheese | Same, including commercially packaged foods and instant mixes. | Highly salted meats as listed. Processed foods (except low sodium products). Limit cheese and salted peanut butter. |
| Vegetables (limit to 4 serv./ day with no added salt) | Canned vegetables. Sauerkraut. Tomato juice | Limit use of drained canned vegetables. Tomato juice with salt added. |
| Fruits (all ok) | --- | --- |
| Breads and Cereals | Same, except: 3 slices of regular bread allowed per day. | Salted crackers, Potato chips. Bread with salted tops. Snack foods. Instant commercially prepared mixes. |
| Fat and Oils | Same except: 3 pats of regular margarine per day | Salt pork, bacon or bacon bits, salted nuts and seeds |
| Soups (Limit to 1 svg. per day) | Bouillon cubes and canned/dehydrated soup or broth; all soups prepared with added salt or highly salted ingredients. Canned soups. | Same |
| Beverages | Bottled, powdered, frozen or canned beverages containing salt or sodium preservatives. | None |
| Desserts (Limit to 2 svgs per day) | Commercial bakery products | None |

## SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED

| FOOD GROUP | 2 Gram Sodium | No Added Salt |
|---|---|---|
| Miscellaneous | Salt. Seasoned salts such as garlic salt, onion salt, celery salt variety salt mixtures and packaged seasoning mixes, MSG. Olives, pickles, relish. Soy, barbecue and prepared sauces, ketchup, prepared mustard, pickles, salted popcorn. Snack dips. | Limit all items on this list. Any Salt added in cooking. Limit salted peanut butter |

Supplements: All nutrition supplements are permitted with order.

Read product labels when purchasing commercially packaged foods. Choose low sodium foods with no added salt or sodium compounds.

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. Low--Sodium Nutrition Therapy http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=121. Accessed July 286, 20183

Eckel RH, Jakicic JM, Ard JD, Miller NH, Hubbard VS, Nonas CA, de Jesus JM, Sacks FM, Lee I M, Smith Jr SC, Lichtenstein AH, Svetkey LP, Loria CM, Wadden TW, Millen BE, Yanovski SZ, 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk,

Journal of the American Collee of Cardiology (2013), doi: 10.1016/j.jacc.2013.11.003
U.S. Department of Health and Human Services (USDA) and the National Institutes of Health (NIH). What is the DASH Eating Plan?. https://www.nhlbi.nih.gov/health-topics/dash-eating-plan . Accessed July 28, 2018

U.S. Departments of Agriculture (USDA) and Health and Human Services (HHS). Dietary Guidelines for Americans, 2010. 7th Edition, Washington, D.C.: U.S. Government Printing Office, December 2010

# LOW FAT DIET

## I. PURPOSE

To restrict the total fat in the diet to less than 50 grams per day. Reduced fat diet is intended for individuals who are unable to properly digest, absorb, and/or metabolize fat.

## II. INDICATIONS

This diet may be used in conditions where fat is not tolerated, such as diarrhea, steatorrhea, malabsorption syndromes, diseases of the pancreas and the biliary tract. Intestinal alterations and deficiencies of bile acid or pancreatic enzyme or obstruction of pancreatic ducts can cause maldigestion of fat. This diet may be useful in weight loss programs, in conjunction with the No Concentrated Sweets Diet.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

## IV. APPROXIMATE COMPOSITION:

| Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|
| Range 1800-2000 | 95-98 | 237-287 | 50 |

## V. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit Juice | Salad w/Diet Dressing **or** |
| 1 Serving Cereal | 6 oz. Calculated Soup |
| 1 Egg or Alternate | 3 oz. Calculated Meat or Alternate |
| 1 Slice Toast | 3 oz. Calculated Starch |
| 1 Pat Butter / Margarine | 3 oz. Calculated Cooked Vegetable |
| 1 pkt Jelly | 1 Serving Fruit |
| 8 oz. Non-Fat Milk | 1 Slice Bread, 1 Pat Butter / Margarine |
| Coffee, Tea, Decaf | 8 oz. Non-Fat Milk |
| Sugar, Salt, Pepper | Coffee, Tea, Decaf |
| | Sugar, Salt, Pepper |

## Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=107. Accessed July 29, 2018

## LOW FAT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk | Nonfat milk, buttermilk and drinks made with nonfat (0% fat) milk, fruit drinks, except those listed to avoid. Fat Free yogurt. | All beverages made with cream whole milk, lowfat milk, ice cream. Non-dairy creamers containing fat. Half & Half. Regular yogurt. |
| Meat, Fish, Poultry | Lean meat. Fish. Poultry (no skin) Use alternates to red meat at least 4 meals each week. | Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages, hot links. Frozen dinners. |
| Cheese | Cheese made with nonfat milk. Lowfat cottage cheese. | Cheese made with whole milk or cream. |
| Eggs | Any prepared without added fat. | Fried eggs. Use sparingly in daily diet. |
| Vegetables | All prepared without added fat. | Any prepared with added fat. |
| Breads | Enriched breads, low fat cereals, graham crackers, low fat crackers. | Any made with butter, cream, whole milk. Commercial bakery muffins, coffee cakes. |
| Fruits | All fruit: fresh, canned and juices. | Fruit smoothies made with milk. |
| Potatoes or Starches | Plain rice, low fat noodles and pasta, white and sweet potatoes and yams. | Fried potatoes, snack chips, potato chips. Any prepared with cream, half & half, milk, butter, or other fats. |
| Desserts | All fruits, gelatin desserts. Fruit ice, angel food cake. | Any made with butter, chocolate, cream, whole milk, eggs, commercial desserts. |
| Fats (limit to no more than 5 tsp./day) | Margarine, vegetable oil. Minimize use of any fat. | Shortening, lard, any deep-fried foods. Gravy, fatty sauces. Salad dressings. |
| Soups | Fat free, broth-base soups; soups made with nonfat milk. | Commercial soups; soups prepared with fat, whole milk or cream. |
| Beverages | Coffee, tea, decaf. Sodas. Tomato juice. | See Milk and Fruits sections. |
| Sugar, Sweets | Sugar, honey, jam, jelly, syrup, molasses, candies. | Candy containing nuts, chocolate or any containing large amounts of fat or oil. |
| Miscellaneous | Salt, flavorings, mild spices in moderation, cocoa powder. Saltine crackers. | Nuts, olives, cream sauces, peanut butter, Buttered popcorn, pretzels. Snack foods. Commercial doughnuts, pancakes, waffles. |

## LOW CHOLESTEROL DIET

## IV. ~~I.~~ PURPOSE

This diet restricts intake of cholesterol to a level of approximately 300 milligrams per day. The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%.

## V. ~~II.~~ INDICATIONS

This diet is indicated for the residents who have high blood cholesterol levels and are at risk for heart disease. This diet may be useful in weight loss programs.

## VI. ~~III.~~ ADEQUACY:

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

## VII. ~~IV.~~ APPROXIMATE COMPOSITION

| | Calories | Protein (gm.) | Carbohydrates (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1800-2000 | 95-98 | 237-287 | 50 |

## VIII. ~~V.~~ SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit or Juice | Green Salad/Diet Dressing or |
| 1 Serving Cereal | 6 oz. Calculated Soup/Crackers |
| 1 Egg or Alternate (* 3/week) | 3 oz. Calculated Meat or Alternate |
| 1 Slice Toast | 3 oz. Calculated Starch |
| 1 Pat Margarine | 3 oz. Calculated Vegetable |
| 1 Pkt Jelly | 1 Serving Fruit |
| 8 oz. Non-Fat Milk | 1 Slice Bread/1 Pat Margarine |
| Coffee, Tea, Decaf | 8 oz. Non-Fat Milk |
| Sugar, Salt, Pepper | Coffee, Tea, Decaf |
| | Sugar, Salt, Pepper |

Whole grain breads, cereals and starches are served daily.

**Reference**

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. LDL Cholesterol-Lowering Nutrition Therapy. ~~https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=410.~~ https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=466. Accessed July ~~29~~6, 2023~~18~~

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. Heart-Healthy Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=466. Accessed July 6, 2023

## LOW CHOLESTEROL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk | Nonfat milk, 0% fat milk, drinks made with nonfat milk, fruit drinks except those listed to avoid. | All beverages made with cream, whole milk, 2% lowfat milk ice cream or egg yolk. |
| Meat, Fish, Poultry, Cheese (Use alternates to red meat at least 5 times a week) | Lean meat, fish, poultry, without skin. Lowfat cottage cheese, lowfat yogurt. cheese made with nonfat milk. Dry beans and peas. | Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages. Cheese made with milk or cream. |
| Eggs (limit 3 per week) | Any prepared without added fat. Egg substitutes. Egg whites. | Fried eggs. |
| Vegetables | All prepared without added fat, 3-5 servings each day. | Any prepared with added fat, sauces or cheese. |
| Breads, Grains, Cereals | Enriched breads, whole grain cereals graham crackers, low fat crackers. | Any made with butter, cream, egg yolk, whole milk. |
| Fruits | All fruits and juices, 2-4 servings/day. | Smoothies made with milk. |
| Potatoes or Starches | Plain rice, low fat noodles and pasta, white and sweet potatoes and yams. Grits. | Fried potatoes, potato chips, snack chips. Any prepared with fat, milk, butter or cream. |
| Desserts | Fruits, gelatin desserts, Fruit ices, angelfood cake. | Any made with butter, chocolate, egg yolks, milk. |
| Sugar, Sweets | Sugar, honey, jam, jelly, syrup, molasses, plain sugar | Candy containing nuts, chocolate, milk or cream. Most commercial desserts. |
| Fats, Vegetable Oils (Limit to no more than 5 teaspoons per day) | Margarine, vegetable oil and soft tub lowfat spreads. | Gravy, fatty sauces, butter, lard, any deep-fried foods. No palm & coconut oils. |
| Soups | Fat-free, broth-base soups; soups made with nonfat milk. | Commercial soups; soups prepared with cream, fat or milk. |
| Beverages | Coffee, tea, decaf. Sodas. | See Milk and Fruits sections. |
| Miscellaneous | Salt, flavorings, spices. Cocoa powder. | Butter, nuts, olives, cream. Sauces, peanut butter, popcorn. |

# LACTOSE CONTROLLED DIET

## I. PURPOSE

This diet follows the regular diet pattern with restriction or elimination of lactose containing foods and beverages. Since tolerance of lactose is variable, the levels are determined by the individual's tolerance. The elderly may be less tolerant of milk and milk products. Many people find they can tolerate milk in smaller amounts or milk products that have been fermented (e.g. buttermilk, yogurt, and cheese), or cooked (i.e. pudding, custard, cream soups, and sauces).

If a severe restriction is necessary, labels need to be read, avoiding foods containing milk, lactose, milk solids, whey, curd, non fat milk powder, and non fat milk solids. Lactose is sometimes used as a filler in medication. (Lactate, lactalbumin, lactylate, and calcium compounds are salts of lactic acid and do not contain lactose).

## II. INDICATIONS

This diet is designed to prevent or reduce symptoms associated with ingesting lactose-containing products. Lactose, the primary carbohydrate in milk, is a dissaccharide compound of glucose and galactose. Lactose intolerance results when the enzyme lactase is not secreted in quantities sufficient enough to hydrolyze and digest the lactose consumed. Possible symptoms include bloating, flatulence, cramping and diarrhea.

Based on the individual's food choices the diet can provide adequate amounts of all essential nutrients. Calcium, Vitamin D, and riboflavin may be deficient if all dairy products are avoided. Use of nondairy or soy milk products could satisfy the nutrient needs; otherwise, supplementation may be necessary. For a Low Calcium Diet, the Regular diet can be modified to avoid Milk and Milk Products, Sardines, Clams, Oysters, Kale, Turnip Greens, Mustard Greens, and Broccoli.

## III. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 2000-2400 | 90-100 | 250-350 | 90-100 |

## IV. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit or Juice | 6oz. Soup or Salad w/ Dressing |
| 1 Serving Cereal | 3oz. Meat or Alternate |
| 1 Egg or Alternate | 3oz. Starch |
| 1 Slice Toast | 3oz. Vegetable |
| 1 Pat Margarine | 1 Serving Dessert |
| 8oz. Nondairy or Soy Supplement | 1 Slice Bread / 1 Pat Margarine |
| Coffee, Tea, Decaf | 8oz. Nondairy or Soy Supplement |
| Sugar, Salt, Pepper | Coffee, Tea, Decaf |
| | Sugar, Salt, Pepper |

Whole Grain breads, cereals and starches are served daily.

# MODIFIED BLAND - LOW FIBER DIET

## I. PURPOSE

The modified bland-low fiber diet is used to reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. It incorporates soft, non-irritating foods. This diet limits fiber, pepper, citrus fruits, raw fruits (except banana) and raw vegetables. It limits fatty foods, sources of caffeine and foods known to be gas-forming. Dairy products are used. Adjustments are made for individual preferences and tolerances.

## II. INDICATIONS

The intended use of this diet is for people with stated sensitivity to gas-forming foods, "sensitive stomach", a history of peptic ulcer disease, hiatal hernia or reflux, recent GI surgery, radiation therapy to the pelvis and lower bowel. It is not intended for those individuals with a history of diverticulosis unless specifically requested by the resident.

## III. ADEOUACY

This diet may be inadequate in fiber.

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1950-2350 | 95-100 | 185-235 | 95-115 |

## V. SUGGESTED MEAL PATTERN

BREAKFAST
4 oz. Fruit or Juice
1 Serving Hot Cereal
1 Egg or Alternate
1 Sl. White Toast
1Pat Butter / Margarine
8 oz. Low Fat Milk
Decaf, Sugar, Salt

LUNCH & DINNER
6 oz. Soup (Lunch or Dinner)
3 oz. Meat or Alternate
2 oz. Cream Gravy
3 oz. Potato or Alternate
3 oz. Cooked Bland Vegetable
1 Serving Dessert
1 Sl. Bread, 1 Pat Butter / Margarine
8 oz. Low Fat Milk
Decaf, Sugar, Salt

**MODIFIED BLAND – LOW FIBER DIET**

VI. FOODS ALLOWED AND FOODS TO AVOID:

| FOOD GROUP | FOODS ALLOWED | FOODS ALLOWED AS TOLERATED | FOODS TO AVOID |
|---|---|---|---|
| Milk | All | | None |
| Meats, Fish, Poultry, Cheese | All eggs, meats poultry, fish, cheese, except as noted. | Fried foods. | Highly spiced or cured meats. |
| Vegetables | All cooked vegetables, except those to avoid. | Gas producing or irritating vegetables onions, peppers, corn, broccoli, Brussel sprouts, celery, cabbage, lima beans. cauliflower. Tomato products. | Raw vegetables. Legumes. |
| Fruits and Juices | All as tolerated. | Raw fruits and citrus. | None. |
| Breads, Cereals, starches | All refined breads, cereals, Pancake, waffle, French toast, potatoes, rice. . | All whole grain breads. All coarse cereals. Potato chips French fried potatoes. | None. |
| Fats and Oils | All fats in moderation. | All as tolerated. | Highly spiced salad dressings, sauces, gravies. |
| Soups | Cream soups -made with allowed vegetables. | | Soups made with foods to avoid. |
| Beverages | All fruit juices. | Caffeinated and decaffeinated coffee and soft drinks. | Alcoholic beverages. |
| Desserts | All as tolerated. | | |
| Miscellaneous | Salt in moderation. Coconut, catsup, mustard, vinegar. | Popcorn, nuts. Strong spices and seasoning. Chocolate. | Black pepper. Red Pepper Chili powder. Pickles. |

**Reference**

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Fiber Tips. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=101. Accessed July ~~29~~6, 20~~18~~23

# LOW RESIDUE DIET

## I. PURPOSE

This diet limits dietary fiber and laxative foods that produce bulky intestinal residue. It eliminates spices that are known gastric irritants. Stool residue is reduced by limiting intake of fruits, vegetables, dairy products and by eliminating whole grain products.

## II. INDICATIONS

This diet may be used after surgery of the large bowel, after hemorrhoidectomy, or for rectal bleeding, cancer of the large bowel or acute stages of diverticulitis.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1700-1900 | 85-109 | 190-238 | 57-75 |

## V. SUGGESTED MEAL PATTERN

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Clear Juice | 6 oz. Clear Broth (Lunch or Dinner) |
| 1 Serving Refined Cereal | 4 oz. Clear Juice (Lunch or Dinner) |
| 1 Egg or Alternate | 3 oz. Meat or Alternate |
| 1 Slice White Toast | 3 oz. Rice, Noodle or Plain Potato |
| 1 Pat Butter / Margarine | 3 oz. Vegetable |
| 8 oz. Low Fat Milk | 3 oz. Dessert |
| Coffee, Tea, Decaf | 1 Slice White Bread |
| Sugar, Salt | 1 Pat Butter / Margarine |
| | 8 oz. Low Fat Milk (Lunch **or** Dinner) |
| | Coffee, Tea, Decaf |
| | Sugar, Salt |

## LOW RESIDUE DIET

### VI. FOODS ALLOWED AND FOODS TO BE AVOIDED

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk (Limit to 2 cups/day) | Milk of all kinds. Yogurt, smooth or made with unseeded fruits. | Yogurt containing seeded fruits or coconut. More than 2 cups milk per day. |
| Meat, Fish, Poultry, and other lean meats. | Tender, lean beef, chicken, fish, lamb, liver, pork, turkey, shellfish, veal, meats. Foods containing | Highly seasoned or tough meats with gristle. Fried, pickled, smoked or |
| Eggs, Cheese and mild American cheese. Eggs cheese. Fried eggs. | Cottage cheese, cream cheese, Sharp or strongly flavored | nuts, seeds, whole grains. |
| Vegetables (Limit to 2 servings) | Any vegetable juice, pureed vegetables. All of the following if cooked tender: asparagus tips, beets, French cut green beans, carrots, mushrooms, pimiento, Whipped yam, pumpkin, squash. | All other vegetables. Vegetable juices with pulp. |
| Fruits ( 2 servings) | Any fruit juice except prune juice. Pureed fruit and the following cooked soft: escalloped apple (cored & peeled), applesauce, peeled apricots, pitted cherries, fruit cocktail, peeled peaches, peeled pears, peeled plums. | All other fruits including: fresh fruits, seeded fruits, all dried fruits, fruits with skins still on the fruit. Juices with pulp. |
| Breads, Cereals, and Starches | Breads: white, refined wheat, seedless rye, rolls or quick breads made from refined flour, biscuits, cornbread, dumplings. Cooked refined cereals. Cold, flaked or puffed cereal. Pancake, waffle, French toast. Plain sweet rolls. Graham crackers. Saltines, matzo, rusk. Macaroni, noodles, spaghetti, refined rice, white or sweet potatoes (without peel). | Any containing whole grains, bran, dried fruits, nuts or seeds. Doughnuts, pastries. Dried beans and peas. Snack Crackers. Wild rice, unpolished rice. Potato with peel. Corn. |
| Fats and Oils | Avocado, butter, margarine, oils and shortenings, cream. | Salad dressings containing strong spices. |
| Soups | Broths, consommé, soups made mild flavored vegetables. | All other soups. |

**LOW RESIDUE DIET**

VI. FOODS ALLOWED AND AVOIDED ON LOW RESIDUE DIET

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Beverages | Carbonated beverages, coffee, coffee substitutes, tea. | None. |
| Desserts | Cakes, cookies, ice cream, sherbet, plain gelatin, plain puddings, made from food allowance. (All desserts made with milk are to be included in daily allowance) | All pastries, pies and desserts containing coconut, nuts, seeds, or dried fruits. |
| Miscellaneous | Clear jelly, honey, sugar, plain sugar candy, molasses, syrups, marshmallows. | Jam, marmalade, candy with coconut, nuts, seeds or fruits in this column. |
| Salt, spices and herbs except those on the "to avoid" list. Cocoa powder. Gravies and sauces made from foods in the "allowed" list. Vinegar. | | Chili powder, whole garlic black pepper, pickles, relishes, seed spices, and any foods containing these. Popcorn. Pretzels. |

# PURINE RESTRICTED DIET

## I. PURPOSE

This diet eliminates foods that contain 150 mg purine or more per serving. Daily protein intake should not exceed 1gm/kg ideal body weight. The diet should not exceed 3 - 4 oz. meat per meal.

Liberal carbohydrate intake (at least 100 gm/day) is used to prevent tissue catabolism and ketosis. Liberal use of fruits and vegetables and moderate fat intake should aid in the maintenance of or gradual reduction to ideal body weight.

Fluid intake should be at least 2-3 quarts per day to eliminate the uric acid via the urine and prevent the formation of renal calcium.

## II. INDICATIONS

This diet is designed to decrease elevated blood and urinary acid levels for the treatment of gout and/or uric acid stones in conjunction with drug therapy.

## III. ADEQUACY

This diet may be inadequate in thiamin and iron due to the restriction of meat.

## IV. APPROXIMATE COMPOSITION:

| Calories | Protein (gm.) | Carbohydrate (gm) | Fat (gm.) |
|---|---|---|---|
| Range | 1850-2100 | 85-90 | 250-300 | 55-60 |

## V. SUGGESTED MEAL PATTERN:

| BREAKFAST | LUNCH & DINNER |
|---|---|
| 4 oz. Fruit Juice | 6oz. Soup or Salad w/Dressing |
| 1 Serving Cereal | 2oz. Meat or Alternate |
| 1 Egg | 3oz. Starch |
| 2 Slices White Toast | 3oz. Vegetable |
| 1 Pat Margarine | 2 Slices Bread |
| 1 Pkt. Jelly | 1 Pat Margarine |
| 8 oz. Low Fat Milk | 1 Serving Fruit |
| Coffee, Tea, Decaf | 8 oz. Low Fat Milk |
| Sugar, Salt, Pepper | Coffee, Tea, Decaf |
| | Sugar, Salt, Pepper |

**PURINE RESTRICTED DIET**

VI. FOODS TO BE ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Milk and Milk Products (2 cups per day) | Nonfat or milk | Whole milk |
| Meats, Fish, Poultry to 2 times weekly: Salmon, shad, tunafish, white fish, blue fish, crab, oysters, lobster | Limit servings on this list herring, mackerel, shrimp, scallops, mussels. Sweetbreads, liver, | Anchovies, sardines |
| | Limit servings from this list to one time per week: Bacon, beef, chicken soup meat soups, liver, sausages, pork, turkey, veal | heart. meat extracts. meat gravies |
| Meat Alternates | Eggs, peanut butter, nuts, cheese | |
| Vegetables (2 or more servings per day) | All vegetables ok. Limit the following to two times per week or ½ cup/day: | Dried legumes, lentils |
| | Mushrooms, peas, spinach, asparagus, cauliflower | |
| Fruits | All fruits and juices | None |
| Breads, Cereals and Starches (4 or more servings per day) | All refined enriched bread and cereal products Limit the following to 2 servings per week: Whole grain breads and cereals, wheat germ, bran, oatmeal | None |
| | Limit use of higher fat foods such as pancakes, French toast, biscuits, potatoes, enriched rice, barley, noodles, spaghetti, macaroni and other pastas | |

**PURINE RESTRICTED DIET**

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

| FOOD GROUP | FOODS ALLOWED | FOODS AVOIDED |
|---|---|---|
| Fats and Oils (Limit to 3 tsp per day) | Butter or margarine. All fats and Oils | Meat gravies |
| Soups | Cream soups made with lowfat milk and allowed vegetables. Vegetable broth and consommé | Meat bouillon, broth and consommé. Soups made with meat stock base |
| Beverages | Carbonated, chocolate, cocoa, coffee, fruit juices, tea, decaf, lowfat milk | None |
| Desserts Limit desserts high in fat such as pie, cake, cookies, doughnuts, sweet rolls, ice cream | All, except those excluded. | Mincemeat if made with meat |
| Miscellaneous | Iodized salt, herbs and spices, vinegar white sauce, olives, pickles | Bakers and brewers yeast |

Elimination of alcohol: Excessive amounts of alcohol may inhibit the renal excretion of urates due to lactic acid accumulation that can lead to hyperuricemia.

**Reference**

Academy of Nutrition and Dietetics Nutrition Care Manual. Low Purine Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=11. Accessed July 28, 2018

# VEGETARIAN DIET

## I. PURPOSE

Vegetarian meal plans encompass a variety of plant-derived foods and exclude some foods derived from animals.

## II. INDICATIONS

Preferred avoidance of all animal products in the diet except dairy and eggs.

## III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

## IV. APPROXIMATE COMPOSITION:

| | Calories | Protein (gm.) | Carbohydrate (gm.) | Fat (gm.) |
|---|---|---|---|---|
| Range | 1800-2750 | 85-120 | 240-290 | 95-115 |

## V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or Salad w/ Dressing
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Margarine
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Supplements: Supplements are permitted with order.

## Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. General, Healthful Vegetarian Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=7 . Accessed July ~~29~~6, 20~~18~~23.

American Heart Association. Vegetarian, Vegan and Meals without Meat ~~Diets~~. http://www.heart.org/en/healthy-living/healthy-eating/eat-smart/nutrition-basics/vegetarian-vegan-and-meals-without-meat-. Accessed July ~~29~~6, 20~~18~~23

# ALLERGENS

## I. PURPOSE

To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions.

## II. INDICATIONS

Harmful food reactions to:

1. Egg
2. Fish
3. Peanut
4. Milk/Lactose
5. Shellfish
6. Soy
7. Tree Nut
8. Wheat/Gluten

All manufactured food products regulated by the Food and Drug Administration (FDA) that contain food allergens as an ingredient must list~~ed with~~ the ~~word of the~~ "food allergy" on the product label. Food allergens are identified using the USDA or vendor database, when available.

Other food allergens may include beef, citrus, hot dog, mushroom, pork, red meat, and tuna. To accommodate food allergens/intolerances outside the FDA regulated food allergens, the Clinical Nutrition and Food Service Department can modify any diet to eliminate specific foods in food preferences.

**Reference**

Academy of Nutrition and Dietetics: Nutrition Care Manual. Multiple Food Allergies Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=29. Accessed July ~~28~~6, 20~~18~~23

# ENTERAL NUTRITION

## I. PURPOSE

Enteral products provide total or supplemental nutrition orally or by tube. These formulas help residents achieve improved caloric and nutritional intake by providing calories, protein, carbohydrates, fats and essential vitamins and minerals. Most residents consume these formulas with minimal gastrointestinal intolerance. Appendix 2. provides Laguna Honda's nutrition support formulary.

## II. INDICATIONS

These formulas are designed for residents who are nutritionally at risk, resulting from:

a) inadequate oral intake due to poor appetite, difficulties in chewing and swallowing, stroke, depression, decreased mentation, or other conditions which reduce nutritional intake.

b) hypermetabolic states such as: fever, trauma, cancer, pressure ulcer, sepsis, and wound healing.

Formulas should be used with caution for residents with malabsorption, maldigestion, advanced renal, cardiac or hepatic insufficiency. Specially designed formulas may be needed for these conditions.

Physicians must order a tube feeding according to the product desired, volume required to meet caloric and nutritional needs, the amount of water to assure adequate hydration and the frequency and mode of feeding. The dietitian will provide specific information and calculations for the formula order. However the MD may order less than the dietitians' estimated nutrition support needs due to medical indications or for quality of life.

## III. ADEQUACY

Physicians must order a tube feeding according to the product desired, volume required to meet caloric and nutritional needs, the amount of water to assure adequate hydration and the frequency and mode of feeding. The dietitian will provide specific information and calculations for the formula order. However, the MD may order less than the dietitians' estimated nutrition support needs due to medical indications or for quality of life.

The following diet orders are available for physicians to order.

1. **Tube Feeding, NPO (TF-NPO):** residents who require total nutrition support via enteral nutrition

2. **Tube Feeding W Food (TF-FOOD):** residents who require supplemental nutrition via enteral nutrition in addition to an oral diet. This order must be accompanied by a diet order specifying texture, therapeutics, etc.

Appendix Ttable 3 provides Laguna Honda's nutrition support formulary.

Volume of enteral formulas needed to meet caloric and protein requirements must be individualized by the dietitian according to nutritional assessment guidelines. The volumes to meet 100% RDIs are listed below.

| | | | |
|---|---|---|---|
| **Glucerna 1Cal** | 1420cc | **Nepro** | 944cc |
| **Glucerna 1.2 Cal** | 1250cc | **Osmolite1 Cal** | 1321cc |
| **Glucerna 1.5 Cal** | 1000cc | **Osmolite 1.2 Cal** | 1000cc |
| **Jevity 1.0 Cal** | 1321cc | **Osmolite 1.5 Cal** | 1000cc |

| | | | |
|---|---|---|---|
| ~~**Jevity 1.2 Cal**~~ | ~~1000cc~~ | ~~**Perative**~~ | ~~1155cc~~ |
| ~~**Jevity 1.5 Cal**~~ | ~~1000cc~~ | ~~**Promote**~~ | ~~1000cc~~ |
| | | ~~**TwoCal HN**~~ | ~~948cc~~ |

~~**Appendix 1. A. Table 1: Dietary Reference for Older Adults**~~
**Appendix: Table 1: Dietary References based on Age-Sex~~:~~**

| | | Female, 19-30 | Female, 31-50 | Female, 51-70 | Female, >70 | Male, 19-30 | Male, 31-50 | Male, 51-70 | Male, >70 |
|---|---|---|---|---|---|---|---|---|---|
| **Calorie Level Assessed** | **Source of Goal** | 2000 | 1800 | 1600 | 1600 | 2400 | 2200 | 2000 | 2000 |
| **Macronutrients** | | | | | | | | | |
| Protein (% kcal) | AMDR | 10-35% | 10-35% | 10-35% | 10-35% | 10-35% | 10-35% | 10-35% | 10-35% |
| Protein (g) | RDA | 46 | 46 | 46 | 56 | 56 | 56 | 56 | 46 |
| Carbohydrate (% kcal) | AMDR | 45-65 | 45-65 | 45-65 | 45-65 | 45-65 | 45-65 | 45-65 | 45-65 |
| Carbohydrate (g) | RDA | 130 | 130 | 130 | 130 | 130 | 130 | 130 | 130 |
| Fiber (g) | 14g/1000 kcal | 25 | 25 | 21 | 21 | 38 | 38 | 30 | 30 |
| Added Sugars (% kcal) | DGA | <10 | <10 | <10 | <10 | <10 | <10 | <10 | <10 |
| Total Lipid (% kcal) | AMDR | 20-35 | 20-35 | 20-35 | 20-35 | 20-35 | 20-35 | 20-35 | 20-35 |
| Saturated Fatty Acids (% kcal) | DGA | <10 | <10 | <10 | <10 | <10 | <10 | <10 | <10 |
| 18:2 Linoleic Acid (g) | AI | 12 | 12 | 11 | 11 | 17 | 17 | 14 | 14 |
| 18:3 Linoleic Acid (g) | AI | 1.1 | 1.1 | 1.1 | 1.1 | 1.6 | 1.6 | 1.6 | 1.6 |
| **Minerals** | | | | | | | | | |
| Calcium (mg/d) | RDA | 1000 | 1000 | 1200 | 1200 | 1000 | 1000 | 1000 | 1200 |
| Chromium (mcg/d) | AI | 25 | 25 | 20 | 20 | 35 | 35 | 30 | 30 |
| Fluoride (mg/d) | AI | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 |
| Copper(mcg/d) | RDA | 900 | 900 | 900 | 900 | 900 | 900 | 900 | 900 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Iodine (mg/d) | RDA | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 |
| Manganese (mg/d) | AI | 1.8 | 1.8 | 1.8 | 1.8 | 2.3 | 2.3 | 2.3 | 2.3 |
| Selenium(mcg/d) | RDA | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 |
| Chloride (g/d) | AI | 2.3 | 2.3 | 2 | 1.8 | 2.3 | 2.3 | 2 | 1.8 |
| Molybdenum (mcg/d) | RDA | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 |
| Iron (mg/d) | RDA | 18 | 18 | 8 | 8 | 8 | 8 | 8 | 8 |
| Magnesium (mg/d) | RDA | 310 | 320 | 320 | 320 | 400 | 420 | 420 | 420 |
| Phosphorus (mg/d) | RDA | 700 | 700 | 700 | 700 | 700 | 700 | 700 | 700 |
| Potassium (mg/d) | AI | 2600 | 2600 | 2600 | 2600 | 3400 | 3400 | 3400 | 3400 |
| Sodium (mg/d) | AI | 1500 | 1500 | 1500 | 1500 | 1500 | 1500 | 1500 | 1500 |
| Zinc (mg/d) | RDA | 8 | 8 | 8 | 8 | 11 | 11 | 11 | 11 |
| **Vitamins** | | | | | | | | | |
| Vitamin A (mcg/d) | RDA | 700 | 700 | 700 | 700 | 900 | 900 | 900 | 900 |
| Vitamin E (mg/d) | RDA | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Vitamin D (mcg/d) | RDA | 15 | 15 | 15 | 20 | 15 | 15 | 15 | 20 |
| Vitamin K (mcg/d) | AI | 90 | 90 | 90 | 90 | 120 | 120 | 120 | 120 |
| Vitamin C (mg/d) | RDA | 75 | 75 | 75 | 75 | 90 | 90 | 90 | 90 |
| Thiamin (mg/d) | RDA | 1.1 | 1.1 | 1.1 | 1.1 | 1.2 | 1.2 | 1.2 | 1.2 |
| Riboflavin (mg/d) | RDA | 1.1 | 1.1 | 1.1 | 1.1 | 1.3 | 1.3 | 1.3 | 1.3 |
| Niacin (mg/d) | RDA | 14 | 14 | 14 | 14 | 16 | 16 | 16 | 16 |
| Vitamin B-6 (mg/d) | RDA | 1.3 | 1.3 | 1.5 | 1.5 | 1.3 | 1.3 | 1.7 | 1.7 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Vitamin B-12 (mg/d) | RDA | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 |
| Choline (mg/d) | AI | 425 | 425 | 425 | 425 | 550 | 550 | 550 | 550 |
| Pantothenic Acid (mg/d) | AI | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Biotin (mcg/d) | AI | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 |
| Folate (mcg/d) | RDA | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 |

## Appendix Table 2: Laguna Honda Hospital Oral Supplements Formulary

| Formula | Calories | Carbohydrate (g) | Protein (g) | Fat (g) | Gluten Free | Suitable for Lactose Intolerance | Kosher | Halal | Notes |
|---|---|---|---|---|---|---|---|---|---|
| **Oral Supplements** | | | | | | | | | |
| **Ensure Original** 237 mL/8 oz. (vanilla, choc, strawberry) | 250 | 41 (42, choc) | 9 | 6 | Yes | Yes | Yes | Yes | *Standard formula* |
| **Ensure Enlive** ***Ensure Plus High Protein** 237 mL/8 oz. (vanilla) *substitute | 350 | 44 (40 *) | 20 | 11 (13 *) | Yes | Yes | Yes | N/A | *Concentrated, high protein formula* |
| **LHH Fortified Pudding** 118.3 mL/4 oz. (vanilla, choc) | 246 (243, choc) | 42 (40, choc) | 8 | 5 | Yes | No | Yes | N/A | *Pudding Thick* |
| **Ensure Clear** 237 mL/8 oz. (apple, mixed berry) | 240 | 52 | 8 | 0 | Yes | Yes | Yes | Apple Only | *Clear Liquid* |
| **Glucerna Shake** 237 mL/ 8oz. (vanilla) | 220 | 26 | 10 | 9 | Yes | Yes | Yes | Yes | *Diabetes* |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Nepro w/ Carb Steady** 237 mL/ 8oz. (vanilla) | 425 | 38 | 19 | 23 | Yes | Yes | Yes | Yes | *Dialysis; low in phosphorus, potassium, and sodium* |
| **Suplena w/ Carb Steady** 237 mL/ 8oz. (vanilla) | 425 | 46.4 | 10.6 | 23 | Yes | Yes | Yes | Yes | *Chronic Kidney Disease, not on dialysis* |
| **Protein Modulars** | | | | | | | | | |
| **Beneprotein** 1 scoop/ 7 g (unflavored) | 25 | 0 | 6 | 0 | Yes | Yes | Yes | N/A | *Elevated protein requirements* |
| **Juven** 24g packet (orange) | 80 | 8.4 | 7g L-Arg./ 7g L-Glu | 0 | Yes | Yes | Yes | N/A | *Elevated protein requirments. Contains Phenyalanine.* |
| **Prostat** 30 mL/1 oz. (citrus splash) | 100 | 10 | 15 | 0 | Yes | Yes | Yes | N/A | *Elevated protein requirements* |

## Appendix Table 3: Laguna Honda Hospital Enteral Nutrition Formulary

| Formula | Calories | Carbohydrate (g) | Protein (g) | Fat (g) | Fiber (g) | Osmolality (mOsm/kg H2O) | Na (mg) | K (mg) | P (mg) | Mg (mg) | Water (mL) | mL to meet 100% RDI | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tube Feeding Formulas | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **Jevity 1.0** 1000 mL | 1060 | 154.7 | 44.3 | 34.7 | 14.4 | 300 | 930 | 1570 | 834 | 290 | 835 | 1500 | *Standard formula* |
| **Jevity 1.2** 1000 mL | 1200 | 169.4 | 55.5 | 39.3 | 17 | 450 | 1067 | 2390 | 1200 | 370 | 807 | 1250 | *Standard formula* |
| **Jevity 1.5** 1000 mL | 1500 | 215.7 | 63.8 | 49.8 | 21 | 525 | 1330 | 2180 | 1250 | 420 | 760 | 1000 | *Standard formula* |
| **Osmolite 1.0** 1000 mL | 1060 | 143.9 | 44.3 | 34.7 | 0 | 300 | 930 | 1570 | 835 | 290 | 835 | 1500 | *Low-Residue formula* |
| **Osmolite 1.2** 1000 mL | 1200 | 157.5 | 55.5 | 39.3 | 0 | 360 | 1067 | 2274 | 1200 | 370 | 820 | 1250 | *Low-Residue formula* |
| **Osmolite 1.5** 1000 mL | 1500 | 203.6 | 62.7 | 49.1 | 0 | 525 | 1330 | 2180 | 1250 | 420 | 762 | 1000 | *Low-Residue formula* |
| **Glucerna 1.0** 1000 mL | 1000 | 95.6 | 41.8 | 54.4 | 14.4 | 355 | 930 | 1325 | 705 | 285 | 853 | 1420 | *Diabetic formula* |
| **Glucerna 1.2** 1000 mL | 1200 | 114.5 | 60 | 60 | 16.1 | 720 | 1110 | 2020 | 1200 | 320 | 805 | 1250 | *Diabetic formula* |
| **Glucerna 1.5** 1000 mL | 1500 | 133.1 | 82.5 | 75 | 16.1 | 875 | 1380 | 2520 | 1000 | 400 | 759 | 1000 | *Diabetic formula* |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Nepro with Carb Steady** 1000 mL | 1800 | 160 | 81 | 96 | 25 | 745 | 1050 | 949 | 717 | 169 | 727 | 944 | *Dialysis formula* |
| **Perative** 1000 mL | 1300 | 180.3 | 66.7 | 37.3 | 6.5 | 460 | 1040 | 1735 | 870 | 350 | 790 | 1155 | *Peptide-based. Contains arginine* |
| **Promote** 1000mL | 1000 | 130 | 63 | 26 | 0 | 405 | 933 | 2667 | 833 | 280 | 839 | 1500 | *High protein formula* |
| **TwoCal HN** 1000 mL | 2000 | 218.6 | 83.5 | 90.5 | 5 | 710 | 844 | 2110 | 1321 | 414 | 700 | 948 | *Calorie and protein dense* |
| **Vital 1.0** 1000 mL | 1000 | 130 | 40 | 38.1 | 4.2 | 411 | 861 | 1477 | 833 | 280 | 834 | 1500 | *Elemental* |
| **Vital 1.5** 1000 mL | 1500 | 187 | 67.5 | 57.1 | 6 | 671 | 1139 | 2194 | 1251 | 422 | 764 | 1000 | *Elemental, Calorically Dense* |
| **Vital AF 1.2** 1000 mL | 1200 | 110.6 | 75 | 53.9 | 5.1 | 459 | 1266 | 1645 | 1004 | 337 | 811 | 1250 | *Elemental* |

## Appendix Table 4: Diet Abbreviation List

| Abbreviation | Description |
|---|---|
| CLIQ | Clear Liquid |
| DB15 | Diabetic 1500 Calories |
| DB16 | Diabetic 1600 Calories |
| DB18 | Diabetic 1800 Calories |
| DS | Dental Soft |
| FLD10 | Fluid Restricted 1000 cc |
| FLD12 | Fluid Restricted 1200 cc |
| FLD15 | Fluid Restricted 1500 cc |
| FLD18 | Fluid Restricted 1800 cc |
| FLDNO | Fluid Restricted- No fluid |
| FLIQ | Full Liquid |
| HONEY | Thick Liquid Honey |
| LCHOL | Low Cholesterol |
| LFAT | Low Fat |
| LOK | Low Potassium |
| LOPHOS | Low Phosphorus |
| LPURINE | Low Purine |
| LRES | Loe Residue |
| MS | Mechanical Soft |
| MEPV | Mechanical Soft Puree Vegetables |
| MSPFV | Mechanical Soft Puree Fruits and Vegetables |
| NA2 | Sodium 2 gram |
| NAS | No Added Salt |
| NCS | No Concentrated Sweets |
| NECT | Thick Liquid Nectar |
| NKA | No Known Allergy |
| NKFA | No Known Food Allergy |
| NOBEEF | No Beef |
| NOCITRS | No Citrus |
| NOEGG | No Egg |
| NOFISH | No Fish |
| NOGLUTWHEAT | No Gluten/Wheat |
| NOHOTDOG | No Hot Dog |
| NOLACT | No Lactose |
| NOMILKPROD | No Milk Products |
| NOMUSH | No Mushrooms |

| | |
|---|---|
| NOPNUT | No Peanut |
| NOPORK | No Pork |
| NORDMT | No Red Meat |
| NOSHELLFISH | No Shellfish |
| NOSOY | No Soy |
| NOTREENUT | No Tree Nuts |
| NO TUNA | No Tuna |
| NPO | Nothing By Mouth |
| PUR-FULL | Puree-Full |
| PUR-SEIMI | Puree-Semi |
| REG | Regular |
| REN60 | Renal Diet, 60 g protein |
| RMSE | Regular with Mechanical Entree |
| TF-FOOD | Tube Feeding with Food |
| TF-NPO | Tube Feeding, NPO |
| TFPR | Tube Feeding with Puree |
| VEG | Vegetarian |

**~~Appendix 1. B Table 2: Dietary Reference for Older Adults~~**

**~~Appendix 1.C. Table 3: Dietary Reference for Older Adults~~**

## ~~Appendix 5. Directions on Finding The Diet Manual on the Laguna Honda Intranet~~

~~Please follow these directions:~~

1. ~~Open Internet Explorer Browser~~
2. ~~The **Laguna Honda Intranet homepage** will open up~~
3. ~~Under **Policies and Procedures** (on the far right side) *click* on **Departmental P&P***
4. ~~*Click* on **Diet Manual**~~

4.

**~~Sources:~~ References**

Institute of Medicine. 2006. *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11537.

IOM (Institute of Medicine). 2011. Dietary Reference Intakes for Calcium and Vitamin D. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. 2019. *Dietary Reference Intakes for sodium and potassium.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25353.

Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: \ Long-Term Care, Post-Acute Care, and Other settings. *Journal of Academy of Nutrition and Dietetics.* 2018;118:724-735.

State O ~~O~~perations Manual Appendix PP-Guidance to Surveyors for Long Term Facilities. 2023, Rev 211: 375.

~~1.~~ Accessed 7/5/2023, https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

## *1.11 Nutritionally Adequate Menus*

~~Established and~~ Revised: 8/23~~ 03/87, 02/89, 5/97, 8/04, 9/06, 7/09~~
~~Reviewed: 8/12, 8/13, 8/14, 8/15, 8/18~~

**Policy**: All menus are assessed for nutritional composition.

**Purpose**: To assure that menus meet the nutritional requirements set forth in the Recommended Daily Dietary Allowances and the RDIs established by the National Academy of Sciences.

**Procedure**:

- Menus are submitted to the Clinical Dietetic Staff for review and approval.
- ~~•~~ Approved menus are assessed for nutritional adequacy using the CBORD system.~~nutritional accounting program.~~
- Any menus which do not meet current standards are revised to provide appropriate nutrients.
- Nutritional composition of menus is assessed as menus are revised.
- When a modified diet does not meet the standards, it is noted in the diet manual.

## *1.12 Registration of Dietitians*

~~Established and~~ Revised: ~~3/84, 3/85, 10/87, 12/87, 1/89, 5/97, 8/04, 9/06, 7/09, 8/12~~8/23
~~Reviewed: 8/12, 8/13, 8/14, 8/15~~

**Policy**: All Clinical Dietitians, Dietetic Technicians and the Chief Dietitian are required to maintain registration with the Academy of Nutrition and Dietetics through the Commission on Dietetic Registration.

**Purpose**: To keep appraised of developments in nutrition science and Medical Nutrition Therapy. To ensure that all nutrition professionals maintain current clinical knowledge and expertise in their field.

**Procedure**:
The Chief Dietitian will record clinical dietetic Registration and maintain current copies of the Academy of Nutrition and Dietetics registration cards for each individual. The Chief Dietitian will routinely notify Human Resources of current registration, by sending copies to human resources for inclusion in the employees' file.

Note:

**Headquarters**
Academy of Nutrition and Dietetics
120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
Phone: 800/877-1600

**Washington, D.C. Office**
Academy of Nutrition and Dietetics
1120 Connecticut Avenue NW, Suite 480
Washington, D.C. 20036
Phone: 800/877-0877

**Phone:** Chicago: 800/877-1600 and one of the extensions below
Washington, D.C.: 800/877-0877

## *1.13 Drug-Food Interactions*

~~Established and~~ Revised: 8/23~~ 3/96, 5/97, 5/99, 12/02, 8/04, 9/06, 7/09, 2/19~~
~~Reviewed: 8/12, 8/13, 8/14, 8/15, 8/18, 2/19~~

**Policy**: Residents receiving medications shall be screened to prevent drug-nutrient interactions. The Pharmacy and the Clinical Nutrition Department shall be notified of residents receiving medications that require dietary instructions.

**Purpose**: To reduce the potential risk of harm or a compromise in therapy posed by clinically significant drug-nutrient interactions.

**Procedure**:
Physician and pharmacy medication orders placed through the EHR shall trigger a notification to the unit based Registered Dietitian via a drug nutrient alert report.

- The Dietitian shall review the resident's diet and the related drug-nutrient interactions and ~~make adjustments~~adjust in the dietary pattern as needed. Language shall be placed in the CBORD notes section of the card file stating that there is a modification of the dietary regimen required by medication orders. In conjunction with Pharmacy protocol, the following table shows the selected medications and dietary significance with potential interaction.

| Drug Name | Dietary Significance | Recommended Actions |
|---|---|---|
| ***Anticoagulants***<br>Warfarin<br>Coumadin | Excessive intake of food with high Vitamin K content may inhibit effect of drug. | Patient should be cautioned about sudden changes in dietary intake of foods containing Vitamin K. |
| ***Antibiotics, Misc.***<br>Metronidazole<br>Flagyl | Causes unpleasant, metallic taste; may cause nausea, vomiting; alcohol may cause flushing. | Take oral medications with food to minimize GI effects; avoid alcohol during administration and for at least one day following. |
| Isoniazid | Food reduces drug absorption; may cause nausea, vomiting; has mild MAOI effect. | Take on an empty stomach, if possible; if GI distress occurs take with food; avoid foods high in tyramine. |
| Tetracyclines/Fluoroquinolones<br>Achromycin, Sumycin, Others<br>Ciprofloxacin, Levofloxacin | Calcium inhibits absorption of drug. | Dairy products should not be taken one hour before or after drug; may be taken with small amounts of low-calcium food to minimize GI distress if necessary. |

| | | |
|---|---|---|
| ***Antineoplastics***<br>Procarbazine<br>Matulane | Alcohol may cause flushing; tyramine- containing foods may cause acute hypertension. | Avoid alcohol and foods high in tyramine. |
| ***Monamine Oxidase Inhibitors***<br>Pargyline<br>Eutonyl | Tyramine-containing foods cause acute hypertension, headache, tachycardia. | Avoid foods high in tyramine. |
| | | |
| ***Monamine Oxidase Inhibitors***<br>Phenelzine<br>Nardil | Tyramine-containing foods cause acute hypertension, headache, tachycardia. | Avoid foods high in tyramine. |
| Selegiline<br>Eldepryl | Tyramine-containing foods cause acute hypertension, headache, tachycardia. | Avoid foods high in tyramine. |
| Tranylcypromine<br>Parnate | Tyramine-containing foods cause acute hypertension, headache, tachycardia. | Avoid foods high in tyramine. |
| ***Psychotherapeutic Drugs***<br>Lithium<br>Eskalith | Salt restricted diet potentiate drug toxicity. Increased sodium intake decreases therapeutic response to drug. | Extremely large or small salt intake must be avoided. |

- The Dietitian shall review any noted food interactions and provide the counseling appropriate for the resident. The potential for a drug-nutrient interaction shall be noted by the Dietitian in their assessment note and resident care plan.
- Counseling information shall be available for the resident and caregivers so that the appropriate dietary precautions are taken. Nursing and Pharmacy personnel shall assist Clinical Nutrition by ensuring those residents or their caregivers have a copy of these instructions if discharged on one of the designated medications. A one week notice prior to discharge is requested for individual discharge diet instructions from the Clinical Nutrition department.

Attachments: None
Reference:
Pharmacy policy 06.04.00: Policy and Procedure for drug-food interaction counseling

# *1.15 Diet Manual Approved by Medical Staff*

~~Established and~~ Revised: ~~05/85, 04/86, 4/87, 8/88, 5/97, 8/04, 9/06, 7/09,~~ 8/18 ~~8~~/23
~~Reviewed: 8/12, 8/13, 8/14, 8/15,~~ ~~8/18~~

**Policy**: The Laguna Honda Hospital Diet Manual has been written by the staff of Dietitians in the Clinical Nutrition ~~Services~~ Department and is available to Medical, Nursing and ~~Nutrition Services~~Dietetic personnel ~~staff~~ for reference. It is reviewed annually and revised at least every five years to ensure that it remains current.

**Purpose**: To standardize the principles of dietary treatment and practical applications of current practice. ~~-~~To serve as a method of communication among physicians, nurses and dietitians, as a guide to kinds and amounts of foods served to residents.
~~To serve as a method of communication among physicians, nurses and dietitians, as a guide to kinds and amounts of foods served to residents~~.

**Procedure**:

1. The Manual is reviewed annually and revised as necessary to incorporate the latest trends in clinical nutrition. The recommended revisions are submitted to the ~~Nutrition Committee~~ Medical Executive Committee and Nursing Executive Quality and Safety Committee as applicable for review.

~~1.~~2. Once approved by the Medical and Nursing Staff the revised manual is sent to through the Annual Quality Management and Executive Committee review process before final approval through the Joint Commission Committee.

~~2. The revised Manual is submitted to the Medical Staff who pass the manual to the Quality Assurance Committee of the hospital for approval annually.~~

3. A written cover sheet noting the acceptance of the ~~revision~~revision, or the review must be signed by the Medical Director and the Chief Dietitian. This cover sheet precedes ~~is placed at~~ the opening page of the ~~all~~ diet manual~~s~~. The approved revised version is uploaded to the Laguna Honda Intranet web page.

## *1.16 Nutrition Screening and Documentation ~~In the Electronic Health Record (EHR)~~Process*

Revised: 8/23

**Policy**: All residents admitted shall receive a nutrition and hydration screening. A complete comprehensive assessment, quarterly review and reassessment shall be documented in the EHR according to the guidelines mandated by California Code of Regulations- Title 22, Center for Medicare and Medicaid Services (CMS) guidelines, and the OBRA Federal Statute.

**Purpose**: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT) and comply with the State and Federal guidelines.

**Procedure**:

~~The dietetic technician (DTR) or Registered Dietitian (RD) shall complete the initial screening for nutrition risk within 48 hours and 7 days of admission (this includes the MDS, section K information). Newly admitted or readmitted residents shall have a comprehensive assessment written by an RD within 14 days of admission. Residents admitted to the medical or rehabilitation acute unit shall be assessed and a nutritional assessment completed within 3 working days ( day of admission day zero) or as needed by nursing risk assessment/MD consult.~~

1. The dietetic technician (DTR) or Registered Dietitian (RD) shall complete the initial screening for nutrition risk within 48 hours for newly admitted/readmitted residents to identify immediate nutrition needs. A baseline care plan must be developed by the RD within 48 hours of a resident's admission.

2. Within 7 days of admission, the K section of the MDS is completed by the DTR/RD and any other associated CAA section that is identified that needs to be filled out by the RD/DTR. The CAA summary is formulated by the RD. ~~Newly admitted/readmitted residents shall have an initial nutrition risk screening completed in the EHR to identify immediate nutrition needs. The RD follows the protocol for nutrition assessment and MDS care planning, working along with the RCT. The K section of the MDS is completed by the DTR/RD and any other associated CAA section that is identified that needs to be filled out by the RD/DTR. The CAA summary is formulated by the RD.~~

~~1.~~3. Newly admitted or readmitted residents shall have a comprehensive assessment written by an RD within 14 days of admission. Residents admitted to the medical or rehabilitation acute unit shall be assessed and a nutritional assessment completed within 3 working days (day of admission day zero) or as needed by nursing risk assessment/MD consult.

~~2.~~4. The Nutrition Care Process (NCP) is used to provide a standardized language through the use of terminology organized by each NCP step, which include: Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD and DTR, in providing individualized high-quality nutrition care. The RD or DTR documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff and ancillary departments. The ADIME guidelines are below:

   i. ADIME:

a. ASSESSMENT: Nutrition assessment is a systematic method for obtaining, verifying and interpreting data needed to identify nutrition-related problems, their causes and their significance. Data is obtained in the review of clinical history, laboratory indices, discussions with the resident and the health care team. Current food intake from daily meals and supplemental foods are determined through meal observations, contacts with nursing staff and review of the chart notes. When the primary source of nutrition is from enteral feedings, a nutrition professional evaluates the adequacy and suitability of the formula for the resident. It consists of the following elements:
    i. Food/Nutrition related history
    ii. Anthropometric measurements
    iii. Biochemical data, medical tests, and procedures
    iv. Nutrition-focused physical findings
    v. Client history

~~v.~~

b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
    i. Intake
    ii. Clinical
    iii. Behavioral-Environment

c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. The RD calculates the resident's individual nutrient needs for calories, protein, fluid and other nutrients. Therapeutic restrictions in the diet, the resident's personal food and ethnic preferences and other meal requests are used to develop the meal pattern and immediate goals of nutrition therapy. The RD considers the expected degree of dietary compliance for the resident. Diets are liberalized when appropriate.

~~c.~~d. Four domains of nutrition intervention have been identified:
    i. Food and/or Nutrition Delivery
    ii. Nutrition Education
    iii. Nutrition Counseling
    iv. Coordination of Nutrition Care

~~d.~~e. MONITORING/EVALUATION: The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
    i. Food/Nutrition-Related History
    ii. Anthropometric Measurements
    iii. Biochemical Data, Medical Tests, and Procedures
    iv. Nutrition-Focused Physical Findings

5. Clinical nutrition protocol and guidelines as outlined in Standards of Practice for Clinical Nutrition: Laguna Honda Hospital ~~and guidelines~~ are used by the RD to assess the resident's current nutritional status ~~to determine the number of criteria and level of nutrition risk for each resident~~. The RD shall complete a review of the resident's nutritional status and the care plan at least quarterly in the EHR, or more frequently as nutritional risk warrants. A comprehensive annual assessment shall be completed in the fourth quarter of each year.

~~Criteria for Determining Nutritional Status and Prioritizing Follow-ups~~

~~Albumin, serum, CBC indices, Transferrin,~~
~~Other laboratory indices of nutritional depletion~~
~~Significant Weight Changes~~
~~Food intake pattern (consistently less than 75%)~~
~~Medical problems having nutritional implications~~
~~Fever, sepsis, infection, decubitus ulcers, insulin dependent Diabetes (with complications) dysphagia, anorexia, malabsorption / diarrhea, long bone fractures, organ failure, cancer, cancer chemotherapy or radiation therapy~~
~~Drug / Nutrient interactions~~
~~The RD shall evaluate the nutrition triggers to be care-planned and those which do not need intervention. The care plan for nutritional care is documented in the Care Plan section of the EHR along with the initial assessment & the associated CAA. In cooperation with the RCT, the nutrition goals and interventions are developed for nutrition problems triggered in the assessment.~~

| ~~Number of Criteria~~ | ~~Risk Level~~ | ~~Assessment Follow-up Care Plan Review~~ |
|---|---|---|
| ~~0~~ | ~~Stable Status / Low Risk~~ | ~~Quarterly~~ |
| ~~2 3~~ | ~~Moderate Risk~~ | ~~within 2 months~~ |
| ~~4 (+)~~ | ~~High Risk~~ | ~~within 1 month~~ |

6. The RD is a member of the RCT and attends weekly or as scheduled RCT meetings to discuss nutritional ~~risk~~status. The plan for the resident's nutritional care is based on goals and interventions discussed in the resident care conference.

7. The care plan for nutrition is coordinated with the resident/caregiver, the core RCT and other ancillary team members, such as speech therapy and occupational therapy. ~~Working with the resident care team in the care planning conference or on a consulting basis, the dietitian assists in developing the care plan.~~ The RD provides expertise in nutritional interventions in acute and chronic diseases, resident nutrition needs, techniques for maximizing independent feeding, food and eating safety, socialization at meals, dietary restrictions in nutrition therapy, individualized meal patterns, food preferences and available menu substitutions. The care plan for nutritional care is documented in the Care Plan section of the EHR along with the initial assessment & the associated CAA. In cooperation with the RCT, the nutrition goals and interventions are developed for nutrition problems triggered in the assessment.

3. ~~The RD is a member of the RCT and attends weekly or as scheduled RCT meetings to discuss nutritional risk. The care plan for nutrition is coordinated with the resident/caregiver, the core RCT and other ancillary team members, such as speech therapy and occupational therapy.~~

~~1. The nutrition follow-up schedule is determined using the Standards of Practice for Clinical Nutrition: Laguna Honda Hospital. The RD shall complete a review of the resident's nutritional status and the care plan at least quarterly in the EHR, more frequently as nutritional risk warrants. A comprehensive annual assessment shall be completed in the fourth quarter of each year.~~

Attachments: Standards of Practice for Clinical Nutrition: Laguna Honda Hospital

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics
https://www.ncpro.org/nutrition-care-process

CMS guidelines

***F692 §483.25 (g)(1)(2)(3)***
***F693 §483.25 (g)(4)-(5)***
***F636 §483.20 (b)***
***F655, F656, F657§483.21 (a)***

# *1.19 Acute Medical/Rehab Admissions/Transfers*

~~Established and~~ Revised: 8/23~~06/88, 03/89, 6/92, 5/97, 3/00, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14, 8/15~~

**Policy**: When Residents are diagnosed with an acute medical problem requiring a transfer to an acute nursing unit, diet orders for meals and supplements will be cancelled. Meals and other scheduled food orders will be held until a new diet order is received from the attending physician.

**Purpose**: To assure that residents receive the appropriate diet for their current medical condition.

**Procedure**:

1. Communications: The Diet Clerks run the daily admission/discharge/transfer report prior to each meal. The diet clerk communicates via EPIC secure chat to the assigned Registered Dietitian (RD) and Dietetic Technician (DTR) and informs them of the admission, discharge, or transfer ~~When a resident is transferred~~ to an acute unit~~, a call is made to notify Nutrition Services of the transfer~~.

2. ~~In the Diet Office, the resident is placed on a NPO diet.~~ Once the resident is transferred, the receiving acute unit ~~will call the Diet Office~~orders the new diet order via EPIC and diet order interfaces with the CBORD system to update the individual residents card file. ~~to record the bed number and the physician's new diet order/enteral feeding formula for the resident.~~ The same process of notification ~~should~~ occurs when the resident leaves the acute unit to return to SNF ~~unit~~~~housing~~.

~~3. These unit and bed changes are entered into the CBORD diet office system. A transfer to an acute unit will automatically change the diet order to NPO. Enter NPO in the diet order section and remove the meal ticket for the next meal(s). Enter the call on the phone log and notify the Dietitian assigned to the care of the resident. *The NPO diet order must be entered to record the transfer to the acute unit, even if the current diet is continued.*~~

~~4.~~3. All foods are discontinued for the resident if on an NPO order. No meals or supplements or other foods will be sent to the resident unless ordered by the Physician and checked by the RD. All nourishment bag meals shall be removed from the tray line set up and nourishment delivery cart ~~Pull any sack lunches or nourishments from the delivery cart~~.

~~5. When you receive a call to either resume the previous diet or begin a new diet, enter the diet as a~~ New ~~diet and notify the assigned Dietitian. Do not resume additional supplements or nourishments without confirmation from the RD. If the diet order requires adjustment from the standard computer models, contact the assigned RD or a staff RD in the office.~~

~~6. When the acute unit transfers the resident, record the transfer as you do a normal transfer from a skilled nursing neighborhood. The receiving neighborhood will call with the bed number and diet order. If the current diet is continued, just change the neighborhood and bed in the Card File. Notify the Dietitian.~~

# *1.20 Nutrition Screening and Assessment Documentation for Acute Hospital Admissions ~~In the Electronic Health Record (EHR)~~*

~~Established 12/19~~Revised:8/23

**Policy**: All residents admitted to the medical or rehabilitation hospital acute unit shall receive a Nursing nutrition screen within 24 hours of ~~admission .~~admission. A complete comprehensive assessment and follow up shall be documented by the RD in the EHR according to the guidelines established and outlined for determination of priority level.
**Purpose**: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT).
**Procedure**:
Residents admitted to the medical or rehabilitation hospital acute unit shall have a nutritional assessment completed within the guidelines established for low, medium and high ~~risk~~risk.

1. Newly admitted residents shall have a Nursing Nutrition Screen completed in the EHR to identify nutrition needs. The RD follows the guidelines for identifying risk level and completes the nutrition assessment.

2. The Nutrition Care Process (NCP) is used to provide a standardized language ~~through the use of~~using terminology organized by each NCP step, which ~~include:~~include Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD in providing individualized high-quality nutrition care. The RD documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical ~~staff~~staff, and ancillary departments. The ADIME guidelines are below:
    i. ADIME:
        a. ASSESSMENT: Nutrition assessment is a systematic method for obtaining, ~~verifying~~verifying, and interpreting data needed to identify nutrition-related problems, their causes and their significance. It consists of the following elements:
            i. Food/Nutrition related history
            ii. Anthropometric measurements
            iii. Biochemical data, medical tests, and procedures
            iv. Nutrition-focused physical findings
            v. Client history
        b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
            i. Intake
            ii. Clinical
            iii. Behavioral-Environment
        c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. Four domains of nutrition intervention have been identified:
            i. Food and/or Nutrition Delivery

ii. Nutrition Education
iii. Nutrition Counseling
iv. Coordination of Nutrition Care

d. MONITORING/EVALUATION: The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
   i. Food/Nutrition-Related History
   ii. Anthropometric Measurements
   iii. Biochemical Data, Medical Tests, and Procedures
   iv. Nutrition-Focused Physical Findings

3. Clinical nutrition protocol and guidelines are used by the RD to determine level of nutrition risk for each resident. RD shall document any nutritional recommendations and notify provider through the EHR.

4. The nutrition follow-up schedule is determined by the RD using the Clinical Nutrition guidelines below or shall be adjusted on an individual basis when:
   a. Resident is stable on current nutrition regimen.
   b. Nutrition problems have ~~resolved~~resolved.
   c. Resident transfers to a higher or lower level of care

**Nutrition Risk Level Guidelines for Clinical Nutrition: LHH Food and Nutrition Services**

**Admission Day = Day Zero***

| Category* | High (1 or more from below) (within 24hours) | Moderate (within 72 hours) | Low (within 72 hours) |
|---|---|---|---|
| Nutrition History | • < 50% of goal nutrition intake ≥ 5 days | • <50-75% of goal nutrition intake > 7 days<br>• Food Allergies/intolerances<br>• Food insecurity not addressed<br>Complicated food preferences | • No significant change in recent intake<br>• >50-75% goal nutrition intake<br>• Food insecurity addressed<br><br>Routine food preferences |
| Diet Order | New TPN: Assess **within 24 hours**<br>New Tube Feed: Assess **within 24 hours** | NPO/Liquid diet<br>All other diet orders not listed as high/low (ex. GI related diet, Aspiration risk diet, Liquid diets)<br>Evolving TF/TPN +/-PO plan<br>Stable TF/TPN plan | Regular<br>Mechanical Soft<br>Consistent CHO<br>Renal<br>Cardiac or Low Sodium<br>Fluid Restricted<br>Vegetarian/Vegan |
| Weight History and Nutrition Focused Physical Exam | • Weight loss (unintentional)<br>○ > 2% one week<br>○ > 5% one month | • Weight loss (unintentional)<br>○ ≤ 1-2% one week<br>○ ≤ 5% one month<br>○ ≤ 7.5% 3 months<br>○ ≤ 10% 6 months | • No weight change or otherwise planned intentional weight loss |

| | | | |
|---|---|---|---|
| | ○ > 7.5% 3 months<br>• >10% 6 months | | |
| Nutrition Diagnosis | • -Inadequate enteral/parenteral infusion<br>• -Malnutrition (acute)<br>• | • -Non healing wound<br>• -Altered labs r/t nutrition<br>• - No prior knowledge of therapeutic diet, drug-nutrient interaction or reinforce new diet education | • -Stable or healing wound<br>• -Reinforce existing therapeutic diet or drug-nutrient interaction |
| Other Clinical Indicator | • -Medical dx: malnutrition, failure to thrive, refeeding syndrome, burn, SBO or GI injury<br>• -Unstable outputs (ostomy, emesis, large GI drain output) | • -Medical dx: new nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia)<br>• pressure ulcers all stages<br>• Change in acuity increasing AMS)<br>• -Need to monitor output management (emesis, -ostomy, GI drain)<br>• - Unstable labs warrants nutrition change (i.e. lytes, glucose, triglycerides, renal) | • -Medical dx: stable nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia)<br>• -Stable clinical course<br>• -No persistent GI complaints<br>• -Labs stable or addressed with medication or diet prescription |
| | | | |
| Reassessment/ Follow Up | • Within 3 days | • Within 5 days | • Within 7 days |
| Responsible Party | RD | RD | RD |

*Per RD clinical judgement to assign nutrition risk w/ categories and examples to provide general framework.

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics https://www.ncpro.org/nutrition-care-process

CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 5 CHAPTER 1, ACUTE HOSPITAL - 70273 Dietetic Service General Requirements

## *1.22 Enteral ~~Formulas~~ Formulary Availability*

~~Established and~~ Revised~~: 3/84, 2/89, 5/97, 8/04, 9/06, 7/09~~ 8/23
~~Reviewed: 8/13, 8/14, 8/15~~

**Policy**: All tube feeding formulas should be chosen from the LHH enteral feeding formulary.

**Purpose**: To provide control of the number and types of enteral formulas used in the hospital.

**Procedure**:

1. A list of enteral formulas is provided in the diet office and can be found as an appendix in the Diet Manual. Selections for enteral feeding orders should be made from this list. Nutritional Composition of Formulas may be obtained from the dietitian.

2. If it is necessary to order a product that is not in the formulary, the clinical dietitian and the physician will decide on an appropriate temporary substitute until the product can be acquired. The chief dietitian should be consulted to assure that the product is available.

3. Once the formula has been received, it will be entered into the Diet Office System. On a daily basis, the diet clerk will print a delivery sheet with the correct amount of formulary to be delivered to each ~~ward~~ unit to cover a 24 hour time period.

# *1.23 Discharge Diet Instruction*

~~Established and~~ Revised: ~~3/85, 2/88, 2/89, 5/97, 2/04, 9/06, 7/09~~8/23
~~Reviewed: 8/13, 8/14, 8/15~~

**Policy**: Residents requiring discharge diet instruction will receive instruction from a dietitian prior to discharge.

**Purpose**: To assure that patients leaving the hospital on therapeutic diets receive education on the essentials ~~on~~ of that diet.

**Procedure**:

1. The Registered Dietitian will provide nutritional counseling on those residents being discharged on a therapeutic diet restriction ~~Orders for discharge diet instruction are called to the Diet Office~~ at least 24 hours prior to discharge.

2. The ~~assigned~~ Dd~~d~~ietitian will gather the necessary materials and information for the resident's diet.

3. The dietitian will instruct resident and family members on the essentials of the diet.

4. The dietitian will provide a phone number for follow up calls.

5. The dietitian will document that a diet instruction was given and an assessment of the ability of the resident to understand and comply with the diet in the integrated charting notes.

# *1.25 NPO or Clear Liquid Diet Orders~~Greater Than Three Days~~*

~~Established and~~ Revised: ~~03/87, 5/97, 9/06, 7/09~~8/23
~~Reviewed: 8/13, 8/14, 8/15~~

**Policy**: A Clinical Dietitian is notified when a ~~residen~~resident's diet order changes to ~~t is~~ NPO or ~~on a~~ clear liquid diet~~. for longer than three (3) days~~.

**Purpose**: To assure adequate nutrition intervention.

**Procedure**:

1. Residents who receive a diet order for NPO or clear liquid are noted by the diet clerk and communicated to the unit Dietitian and Dietetic Technician via secure message communication in the EPIC chart.~~on the Diet Order Screening Sheet by highlighting the diet order.~~ The Diet Clerk~~/Diet Technician~~ runs the admission/discharge/transfer report daily and prior to each meal that includes any change in diet.~~this report daily and posts it in the Dietitians' office.~~

2. The regular diet order for the resident is discontinued ~~in the computer~~in EPIC and CBORD. ~~An~~ The new order for NPO is made in EPIC~~entered~~.

3. If the order for NPO or clear liquid diet continues for three days, the Dietitian confers with the nursing staff and the physician. The Dietitian ~~and~~ documents in a ~~makes a~~ nutrition note to ~~the effect~~assess ~~that~~ the ~~the diet is inadequate~~nutritional adequacy of the diet. ~~nutritionally.~~

# Deletion Food and Nutrition Policies and Procedures

# *1.17 Nutrition Assessment as part of the Care Plan Process (see also MDS/CAA process)*

Established and Revised: 11/85, 03/87, 05/89, 8/91, 5/97, 11/98, 6/99, 2/00, 9/02, 6/04, 9/06, 7/09
Reviewed: 8/13, 8/14, 8/15

**Policy**: A Clinical Dietitian will monitor nutritional status of all residents.

**Purpose**: To provide quality nutritional support as an adjunct to resident care.

**Procedure**:

1. Using the Nutrition Services policies and procedures, Nutrition Assessment Protocol and Nutrition Care Guidelines, the clinical dietitian (RD) assesses the resident's current nutritional status. Data is obtained in the review of clinical history, laboratory indices, discussions with the resident and the health care team. From this data, the RD determines the immediate goals of nutrition therapy.

2. The RD calculates the resident's individual nutrient needs for calories, protein, fluid and other nutrients. Current food intake from daily meals and supplemental foods are determined through meal observations, contacts with nursing staff and review of the DNCR chart notes. Therapeutic restrictions in the diet, the resident's personal food and ethnic preferences and other meal requests are used to develop the meal pattern.

3. When the primary source of nutrition is from enteral feedings, a nutrition professional evaluates the adequacy and suitability of the formula for the resident. If adjustments are necessary, recommendations are made to the physician.

4. The clinical dietitian assesses the expected progress of any disease state by interpreting the data and the degree of dietary compliance expected for the resident. Diets are liberalized when appropriate.

5. Working with the resident care team in the care planning conference or on a consulting basis, the dietitian assists in developing the care plan. The RD provides expertise in nutritional interventions in acute and chronic diseases, resident nutrition needs, techniques for maximizing independent feeding, food and eating safety, socialization at meals, dietary restrictions in nutrition therapy, individualized meal patterns, food preferences and available menu substitutions.

6. The plan for the resident's nutritional care is based on goals and interventions discussed in the resident care conference. The nutritional risk level and the nature of the resident care plan determine a follow-up schedule but evaluations are documented at least quarterly.*

7. Dietitian progress notes are charted in integrated charting except for the Initial Screening/ Assessment, which is filed in the Assessment section of the medical record. Annual comprehensive assessments are currently in the Assessment section.

8. Follow-up by a nutrition professional will be made as frequently as nutritional status/risk warrants. This section has been clarified in latest Revision

| | | |
|---|---|---|
| Guidelines are: | Stable and Low Risk Status | Quarterly |
| | Moderate Risk | Within 1 to 3 months |
| | High Risk | Within 1 to 2 months |
| | Acute Status | Daily to Weekly |

# *1.18 Nutrition Screening and Assessment*

Established and Revised: 11/85, 03/87, 05/89, 8/91, 5/97, 11/98, 6/04, 9/06, 7/09
Reviewed: 8/13, 8/14, 8/15

**Policy**: A Clinical Dietitian will monitor nutritional status of all residents.

**Purpose**: To provide quality nutritional support as an adjunct to resident care.

**Procedure**:
The **Nutrition Assessment** is completed by a Registered Dietitian to evaluate the nutritional status of residents upon admission. Through the assessment process, the dietitian reviews and analyzes the medical and personal needs of the resident. The dietitian visits residents to identify food preferences, to increase satisfaction and encourage compliance with nutrition therapy. With the resident care team, the dietitians participate in disease management and provide effective, comprehensive resident care. Nutrition education for residents and individualized counseling for discharge are included in these resident services.

Nutritional care depends on accurate assessments and routine follow-up reviews. As no single criteria is accurate enough for assessing the nutritional status of an individual, a combination of indicators must be used to determine nutritional needs. Identification of nutrition triggers using the MDS and subsequent assessment is essential for establishing the level of nutrition care required. Problem areas must be addressed in care plans developed and coordinated with the resident care team. Follow-ups require reassessment in a timely manner to ensure continuity of care. Some criteria for assessing nutrition status are listed below, including biochemical data and anthropometric data. (See also: The Nutrition Protocol)

Criteria for Determining Nutritional Status and Prioritizing Follow-ups

1. Albumin, serum, CBC indices, Transferrin,
2. Other laboratory indices of nutritional depletion
3. Significant Weight Changes
4. Food intake pattern (consistently less than 75%)
5. Medical problems having nutritional implications
   Fever, sepsis, infection, decubitus ulcers, insulin dependent Diabetes (with complications) dysphagia, anorexia, malabsorption / diarrhea, long bone fractures, organ failure, cancer, cancer chemotherapy or radiation therapy
6. Drug / Nutrient interactions

Information gathered from other sources:

1. Medical and Dietary History
2. Clinical Examination
3. Resident / Family Interviews

| Number of Criteria | Risk Level | Assessment Follow-up Care Plan Review |
|---|---|---|
| 0 | Stable Status / Low Risk | Quarterly |
| 2 – 3 | Moderate Risk | within 2 months |
| 4 (+) | High Risk | within 1 month |

# *1.21 Palliative Nutrition Care*

Established and Revised: 03/93, 5/97, 7/04, 9/06, 7/09, 9/18
Reviewed: 8/13, 8/14, 8/15, 9/18

**Policy**: Residents receiving palliative or comfort care will receive food according to their ability to eat, food preferences and tolerance. Aggressive nutrition interventions are avoided.

**Purpose**: To assure that residents receive the food of their choice, as a first priority. Less emphasis is given to individual nutritional requirements than to the pleasure of taste and enjoyment of food. Foods will be provided for the comfort and pleasure needs of the resident.

**Procedure**: PALLIATIVE NUTRITION CARE GUIDELINES

These guidelines are intended for residents who are in their terminal stages of illness. They may also be useful for residents who indicate a stated preference to avoid treatments where the burdens are heavier than the benefits they provide (comfort care). No aggressive nutrition therapy or treatments are implemented without a request from the resident, including: routine vital signs or weights, labs or blood tests, tube feeding / IV. As a rule, these residents have a 'Do Not Resuscitate' (DNR) order in their advance directives.

## PALLIATIVE AND COMFORT CARE APPROACHES

1. Be aware of comfort signs, note if resident is resting comfortably or has any complaints. It is not unusual if the resident does not eat or drink in the imminent dying process. Often the ability to eat or drink will vary from day to day.

2. The standard diet order for the palliative care unit is liberalized and restrictions are lifted to allow for maximum menu flexibility and the resident's meal enjoyment. Alter food choices and eating patterns to accommodate the residents changing needs. The resident may receive a menu each day to select the foods they wish to eat.

3. Texture modification may be needed to allow the resident to continue to eat solid foods. Changing the food texture from regular to dental soft or mechanical soft may increase the enjoyment of favorite foods. If the resident loses the ability to chew or swallow easily, the diet can be progressively adjusted to serve puree foods. Small frequent feedings with nourishments between meals may be desirable and easier to tolerate.

4. If resident tolerates only certain foods, the RD/DTR shall make every attempt to provide them. A variety of comfort foods may be offered such as : soups, ice cream, milkshakes, ethnic foods, foods brought in from home or outside sources. Oral nutritional supplements and nutrient-dense nourishments may be used to maximize calorie and protein intake. Liquid nutrition may be better tolerated than solids.

5. For pain control, medications such as opioid analgesics, and narcotics: codeine, morphine, and fentanyl may be used. Nausea, vomiting, constipation, or an altered or impaired sense of taste are common side effects of medications and may require adjustments to foods served.

# *1.24 Care Plans to Address Nutrition Problems*

Established and Revised: 3/87, 2/88, 2/89, 5/97, 11/99, 12/99, 3/00, 6/04, 9/06, 7/09, 4/19
Reviewed: 8/13, 8/14, 8/15, 1/19

**Policy**: The Registered Dietitian (RD) shall identify residents with nutritional problems and integrate care plans addressing nutrition into the comprehensive Resident Care Team (RCT) care plan section of the electronic health record (EHR).

**Purpose**: To assure that all residents receive effective nutrition care through a collaborative effort between the RD and the RCT.

**Procedure**:

1. The RD is a member of the RCT and attends Resident Care Conferences (RCC) for residents at nutritional risk. The care plan for nutrition is coordinated with the resident/caregiver, the RCT, and other ancillary team members, such as speech therapy, occupational and physical therapy. The procedures established by the hospital for the Minimum Data Set (MDS) and Care Area Assessment (CAA) care planning process shall be followed for each resident.

2. When a resident is identified to have a nutrition-related problem, the RD shall assess the resident's condition and provide pertinent information to the RCT. The RD shall document the nutrition diagnosis, time-oriented goals, and all pertinent interventions in the EHR nutrition care plan.

3. The care plan shall reflect the nutrition information required in the Resident Assessment Instrument (RAI) process as well as clinical information derived by the initial nutrition screening and assessment. Items that may be included are: diet order, chewing/swallowing ability, allergies, weight status, drug-nutrient interactions, diet history, nutrition focused physical exam, fluid status, pressure injuries, personal food preferences, and social dining choices.

4. The RD shall create the nutrition care plan and enter the documentation into the EHR. The RD shall review the final MDS/CAA/care plan documents for accuracy, and electronically sign his/her documentation in the EHR.

5. The RD shall monitor the resident's progress towards nutrition-related goals during the quarter and modify the care plan interventions as needed. The RD shall present recommendations for changes to the care plan to the RCT at the next scheduled meeting or prior if needed. Care plan goals and interventions shall be updated after discussion with the RCT members and reflected in the EHR documentation.

6. The RD shall complete a follow-up for residents with a significant change in condition that affects nutrition. The nursing staff shall notify the RD by an electronic message or referral when the following occur: significant weight changes, new or non-healing pressure injuries, reduced nutrient intake of food or fluids, difficulty in chewing or swallowing, or initiation of enteral nutrition.

7. The RD shall receive notification of changes in the resident's diet order, enteral nutrition formula order, transfer, discharge, or death through an EHR report, and update any relevant interventions accordingly. If a resident is transferred within the hospital, the sending RD shall discuss the current status of the resident and the resident care plan with the receiving RD. A transfer note shall be written by a nutrition professional (RD/diet technician).

8. The RD shall be notified via an electronic message or referral of less urgent issues, such as resident concerns about food textures or dietary restrictions, changes in food preferences, requests by the resident/family to see an RD, and non-significant weight changes. The RD shall follow-up with the resident/family and modify the resident care plan if necessary.

9. The RD (or a diet technician, supervised by an RD) shall complete a quarterly nutrition review for each resident in the EHR. This review shall summarize the most current nutrition information for the resident including diet order, current weight, improvement or deterioration of nutritional status, changes in medical condition, social dining skills or activities of daily living, and progress toward care plan goals.

10. The RD shall provide the updated information to the RCT and specifically indicate the continuation of effective interventions, the removal of interventions which are not working, and the initiation of new goals and/or interventions.