SUBJECT: INTERDISCIPLINARY TEAM CARE ASSESSMENTS	REFERENCE #4005
DEPARTMENT: SKILLED NURSING	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

Each resident of ___________________ Facility shall have a Plan of Care developed by the interdisciplinary team. Disciplines shall include, but not be limited to, medical, nursing, social service, nutrition, activities and any other discipline indicated in treatment of resident, e.g., physical therapy. Each discipline involved in the care management of residents is responsible for contributing to the development, implementation, coordination and evaluation of the interdisciplinary Plan of Care.

PROCEDURE:

- An interim plan of care plan is initiated on admission to the Facility.
- A medical assessment is completed by the physician within 5 days prior to admission or within 48 hours after admission. Physician's orders for treatment of the resident are implemented on the day of admission by the appropriate nursing personnel. Orders are incorporated into the interim Plan of Care by the RN/LPN/LVN Charge Nurses and/or the Nurse Manager.
- A nursing admission assessment is begun on the day of admission. A comprehensive assessment (MDS) is begun by the 7th day of admission and is completed by the end of the 14th day.
- Social service, nutritional care and activities assessments are initiated by assigned personnel within 48 hours of admission.
- Other disciplines, indicated in the treatment of the resident, complete their assessments when the discipline is ordered by the physician.
- Interdisciplinary Plans of Care are developed, implemented, coordinated and evaluated as follows:
    - Development and implementation of the Plan of Care begins on completion of assessments.
    - Plans of Care for residents are coordinated by RN/LPN/LVN Charge Nurses and/or the Nurse Manager.
    - Plans of Care shall include the care to be given, objectives to be accomplished (which are measurable and time limited) and the staff and/or professional discipline responsible for each element of care.

- Apical pulse and blood pressure should be taken each time prior to dispensing blood pressure medication or cardiac medication when there is a specific physician's order that has a stated parameter to hold and not to be given. The apical pulse and blood pressure are then to be recorded on the Medication Administration Record (MAR).
- Return medicine to resident's medication drawer.
- Hands are to be disinfected between individual resident contact. Hands must be washed with soap and water when contact is made with any type of body fluid.
- Gloves are to be worn when administering any rectal, vaginal or topical medication. Gloves are also to be worn when there is any sign or symptom of infection or drainage. Hands are to be washed upon removal of the gloves.
- Eye drops, eye ointments, topical, rectal or vaginally administered medications are to be kept separate from oral, SQ, IV and IM medication.
- Only one resident's medication is to be prepared at a time.
- The medication cart is to remain locked at all times when a nurse is not in close proximity.
- No medications are to be left unattended on top of the medication cart.

- Documentation of medication:
    - The Medication Nurse signs his/her initials on the bottom of the MAR along with a corresponding signature and title. This must be done on each MAR used.
    - Every dose given is to be initialed.
    - When a medication is omitted, the nurse is to initial and circle the appropriate area. He/she must also give a time and reason for the omission on the reverse side of the MAR with a signature and date.
    - For all intramuscular, subcutaneous and intravenous injections, the injection site must be recorded.

SUBJECT: ENTERAL TUBE MEDICATION ADMINISTRATION	REFERENCE #4028
DEPARTMENT: SKILLED NURSING	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

___________________ Facility ensures the safe and effective administration of enteral formulas and medications. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on the Nursing Department's assessment of the resident's condition. The Nursing Department also consults with the physician, dietitian and Consultant Pharmacist.

PROCEDURE:

- Enteral formulas, equipment, route of administration, and rate of flow are selected based on a nursing assessment of the resident's condition and need. Physicians, pharmacists and dietitians are involved in planning.

- Interactions between medications and feeding formulas, and interactions of multiple medications are considered before administering mediations through the enteral tube. If necessary, information is obtained from the provider pharmacy or Consultant Pharmacist.

- The manufacturer's written recommendations regarding suggested time period for hanging of the product are consulted when determining the schedule for enteral feeding administration.

- Caloric content per milliliter is verified before administration to ensure that the correct dosage is given to achieve caloric objectives.

- When new medication orders are received from the prescriber, the intended route of administration is also obtained. The provider pharmacy is informed that the resident is receiving medications through the enteral tube. Medications for enteral administration are obtained in liquid form whenever possible. The provider pharmacy is consulted to determine the best method for preparing dosage forms for enteral tube administration when liquid formulations are not available.

- Prior to crushing tablets for administration through the enteral tube, the crushing guidelines and list are consulted.

    - Crushed medications: The powder from each medication is mixed with water or another suitable diluent if water is unacceptable, before administration.

    - The enteral tubing is flushed with at least five (5) ml of water between each medication to avoid physical interaction of the medications.

SUBJECT: ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN	REFERENCE #6001
	PAGE: 1 OF: 4
DEPARTMENT: SKILLED NURSING	
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

The Governing Body, Medical Staff and professional service staff of ___________________ Facility will deliver resident care that is consistent with achievable goals for the facility. The Quality Improvement Program is a comprehensive program relating to each department within the Facility. The goal of the program is to change the facility's Quality Improvement focus to Continuous Quality Improvement (CQI) with full integration of the facility's CQI program.

GOALS:

- The goals of this program are:
  - To establish, maintain, support and document evidence of an ongoing quality improvement program that includes effective mechanisms for reviewing, evaluating and monitoring resident care and for appropriate response to findings;
  - To establish priorities for problem assessment by focusing on the resolution of known or suspected problems that impact residents and/or by focusing on areas with potential for substantial improvement in resident care;
  - To evaluate the results of the actions taken by individual departments and to maximize the efficient use of resources available within the Facility and the community;
  - To integrate the needs of Facility personnel to allow continuity of care for residents from admission to discharge through the CQI process;
  - To provide ongoing reports to the facility's Quality Improvement Committee and the Board of Directors on the findings of the facility's Quality Improvement Program;
  - To educate all department personnel of the ongoing CQI process and its integration with the acute hospital CQI program.

DEFINITION:

- Quality improvement refers to those activities or program components designed to evaluate resident care and to identify, study and correct deficiencies found in the resident care process. The quality improvement activities will include:
  - Interdisciplinary review of physicians, nurses and ancillary staff using objective criteria;
  - Providing recommendations;
  - Monitor follow-up and perform reassessment of follow-up results.

POSITION DESCRIPTION / PERFORMANCE EVALUATION

Job Title: LVN/LPN, Skilled Nursing Facility

Supervised by: RN Supervisor or Nurse Manager, Director of Staff Development

Prepared by: ________________________ Date: ___________

Approved by: __________________ Date: ___________

Job Summary: Assesses, plans and implements the nursing care of residents within the skilled nursing setting with the supervision of a Registered Nurse. Responsible for ensuring continuity of care of the residents between shifts by providing direct care as well as supervising the care given by CNAs and supportive staff members. Participates in resident and family teaching. Maintains role as resident advocate with a focus on the facility's mission.

DUTIES AND RESPONSIBILITIES:

E = Exceeds the Standard M = Meets the Standard NI = Needs Improvement

Demonstrates Competency in the Following Areas:	**E**	**M**	**NI**
Assesses residents on admission and on a weekly basis as well as when conditions change. Documents appropriately including Minimum Data Sets under the supervision of a Registered Nurse.	2	1	0
Assesses the resident's condition and nursing needs, prescribes appropriate nursing action.	2	1	0
Documents changes in residents condition and nursing care on Progress Notes and Care Plan.	2	1	0
Meets current documentation standards and policies.	2	1	0
Notifies physician of changes in resident's condition and follows through until appropriate action is taken.	2	1	0
Notes and carries out physician's orders in a timely manner.	2	1	0
Gives a thorough report to oncoming shift by participating in walking rounds and documenting appropriately on calendar for upcoming needs.	2	1	0
Follows through as needed on information given by shift report, resident or family regarding resident concerns.	2	1	0
Implements Plan of Care of the resident based on assessments and goals established by the Interdisciplinary Care Team.	2	1	0
Supervises other members of the health care team as needed to accomplish the Plan of Care which has been developed.	2	1	0
Demonstrates competence in technical and manual skills according to scope of practice for LVNs/LPNs.	2	1	0
Functions as a resident advocate by protecting the resident's rights.	2	1	0
Administers medications using the five "rights" and performs treatments safely.	2	1	0
Demonstrates creativity in solving problems and looking at situations in new and innovative ways.	2	1	0
Interacts with residents, families, co-workers, managers and other Departmental personnel in a kind, knowledgeable and friendly manner.	2	1	0
Consistently involves resident and family in planning for care, treatment, teaching needs and discharge plans.	2	1	0