List of Hospital-wide/Department Policies & Procedures
Submitted to JCC for Approval on January 10, 2017

1. **a. New Hospital-wide Policies and Procedures**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Policy &amp; Procedure Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHPP 73-16</td>
<td>Confined Space Program</td>
<td>Created for workplace safety and to meet Title 8 Sections 5157 and 5158 requirements.</td>
</tr>
</tbody>
</table>

**b. New Department Policies and Procedures**

**Department: Nursing**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPP D08-07</td>
<td>Laguna Honda Hospital and Rehabilitation Center Substance Treatment and Recovery Services (LHH STARS)</td>
<td>Created to describe substance treatment and recovery services offered at LHH.</td>
</tr>
</tbody>
</table>

2. **a. Revised Hospital-wide Policies and Procedures**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHP 20-01</td>
<td>Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units</td>
<td>Adds admission criteria to the Acute Rehabilitation Unit; requires approval by CEO, CMO and CNO for patients in police custody; specifies required TB screening for new admissions and further details behavioral screening procedures described in Appendix B.</td>
</tr>
<tr>
<td>LHHP 24-13</td>
<td>Falls</td>
<td>Clarifies the definition of a fall.</td>
</tr>
<tr>
<td>LHHP 72-01 C24</td>
<td>Employee Influenza Vaccination Policy and Use of Surgical Mask When Vaccination is Declined</td>
<td>Clarifies that staff who have not received the influenza vaccine is required to wear a surgical mask for the duration of the influenza season when in the hospital building except staff break rooms.</td>
</tr>
</tbody>
</table>

**b. Revised Department Policies and Procedures**

**Department: Nursing**
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPP D9 9.0</td>
<td>Maintaining Temperature of Medication and Nourishment Refrigerators via Temp Trak and Cleanliness of Refrigerators</td>
<td>Adds procedures for addressing out of range temperature readings for the nourishment refrigerators and galley freezers by the Licensed Nurse.</td>
</tr>
<tr>
<td>NPP 1 5.0</td>
<td>Oxygen Administration</td>
<td>Added description of what is considered a disposable oxygen device; required labeling of disposable tubing with date and initials every 24 hours and as needed; and that AM shift Nursing staff are responsible for replacing disposable oxygen administration devices.</td>
</tr>
<tr>
<td>NPP J 1.1</td>
<td>Obtaining, Handling, and Storage of Medications</td>
<td>Added that unlabeled and expired medications are to be discarded in the medication waste bin.</td>
</tr>
<tr>
<td>NPP K 9.0</td>
<td>Management of Residents on Hemodialysis</td>
<td>Added to policy that residents on hemodialysis are to be weighed daily at the same time each day, and that communication between licensed nurses and the dialysis center shall be documented in the integrated progress notes.</td>
</tr>
</tbody>
</table>

3. **Hospital-wide Policies and Procedures for Deletion**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Deletion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>None.</td>
</tr>
</tbody>
</table>

**Department Policies and Procedures for Deletion**

**Department:**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>None.</td>
</tr>
</tbody>
</table>
CONFINED SPACE PROGRAM

POLICY:
Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to preventing workplace injury and illness due to hazardous environments.

PURPOSE:
To implement and maintain an effective Confined Space Entry Program, pursuant to Title 8, Sections 5157 and 5158 for a Permit Required Confined Space Program and consistent with the City and County of San Francisco Department of Public Health Occupational Safety and Health Policies.

DEFINITIONS:

1. Confined Space

A space that:
- Is large enough and so configured that an employee can bodily enter and perform assigned work;
- Has limited or restricted means for entry or exit;
- Is not designed for continuous employee occupancy.

2. Permit Required Confined Space

A confined space that:
- Contains or has a potential to contain a hazardous atmosphere; or
- Contains a material that has the potential for engulfing an entrant; or
- Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross section; or
- Contains any other recognized serious safety or health hazard.

PROCEDURE:

1. Confined Space Identification and Characterization

Confined spaces that either Laguna Honda employees or contractors may enter have been identified in Appendix A and the flow chart in Appendix B. is used to determine whether or not an entry permit is required.
2. General Procedures for Work in Confined Spaces

a. Any Laguna Honda employee planning to enter a confined space must complete the pre-entry safety checklist (Appendix C).

b. Any employee planning to enter a confined space must notify a Facility Services Supervisor prior to entry. If a Supervisor is not available, entry is not permitted.

c. Neither Laguna Honda employees nor contractors may enter any permit required confined space before either Workplace Safety staff, the Chief Engineer, or designee has signed an entry permit.

d. If the hazards, potential hazards, or hazards introduced by a work procedure can be effectively removed the space may be classified back to non-permit confined space. Only Workplace Safety staff, the Chief Engineer, or designee may make this determination.

e. Entry into non-permit confined spaces outside of normal business hours (prior to 7am and after 5pm) is not permitted except in an emergency. If deemed absolutely necessary by the Watch Engineer, entry can be made after notifying SFSD at 4-2319. SFSD must also be contacted every 30 minutes and upon exiting the space.

f. Entry into a permit required confined space outside normal business hours is prohibited.

3. Non-Permit Entry Procedures

The employee requiring access to the space will:

a. Perform a visual inspection of the confined space without crossing the barrier of the entry access point.

b. Complete the ENTRANT section of the pre-entry safety checklist (Appendix C).

c. If all questions on the ENTRANT section pre-entry safety checklist are answered NO:
   i. Review pre-entry safety checklist with a Supervisor.
   ii. Notify designated Supervisor of entry time.
   iii. Establish contact with designated Supervisor at each 30 minute interval of occupancy and upon exiting space

d. If any question on the ENTRANT section of the pre-entry safety checklist is answered yes, the space is re-classified as a permit required confined space.
i. DO NOT ENTER space.
ii. Secure entry access point.
iii. Provide the pre-entry safety checklist to a Supervisor and follow the procedures for entry into a permit required confined space.

4. Permit Entry Procedures

a. A Facility Services Supervisor will review the pre-entry checklist and the following information to draft a confined space entry permit (Appendix D):
   I. Uses of confined space, which may adversely affect the atmosphere.
   II. Physical characteristics, configuration and location of the confined space.
   III. Existing or potential hazards.
   IV. Safety Data Sheets (SDS’s) for any product to be used in the operation.
   V. Lockout requirements.
   VI. Processes to be used in the confined space such as cutting or welding.
   VII. Emergency Response capabilities.

b. The Supervisor will provide the draft entry permit to Workplace Safety staff or the Chief Engineer, who will develop a strategy for mitigating the unsafe condition or the hazard introduced by a work procedure (chemicals, or hot work) and complete the Entry Permit, and if applicable, the Hot Work Permit. The control strategy may include one or more of the following methods:
   i. Pre entry atmospheric testing
   ii. Continuous atmospheric testing (personal and/or area)
   iii. Use of an entry attendant
   iv. Natural ventilation
   v. Mechanical ventilation
   vi. Lockout/Tagout procedures
   vii. Use of respirators or other personal protective equipment
   viii. Use of safety equipment (fire extinguishers, barricades, etc.)

c. The LHH IH or Chief Engineer will sign the entry permit, make it available to entrants and post it at the entry site.

d. Prior to entry the LHH IH or Facilities Services Safety Engineer or designee will conduct a safety tailgate meeting with the entrants and attendants to address all aspects of the entry permit and an emergency response plan.

e. Whenever anyone enters a permit-required confined space, an attendant is required to:
i. Be present at all times when employees are in the permit required confined space and shall limit activities to assisting in confined space operations.

ii. Maintain continuous communications with entrants by radio or voice.

iii. Restrict entry in the confined space to those specified on the permit.

iv. Monitor activities of the confined space.

v. Order an evacuation and summon/initiate rescue from outside the confined space.

vi. Remain stationed outside the confined space unless replaced by another trained attendant.

f. All atmospheric testing will be completed an authorized employee trained in gas detector use according to the following protocol:

i. Check the condition of the detector, including current calibration, battery charge, and proper working order. Do not use a meter that is not calibrated or not functioning properly.

ii. The detector should be used in a clean environment for several minutes before testing the atmosphere in the confined space.

iii. The confined space atmosphere will be tested in the following order:

   iv. Oxygen content
   v. Flammable gases and vapors
   vi. Toxic air contaminants

   vii. Testing will be performed to attain reading from the top, middle and bottom of the confined space.

   viii. The space will be monitored as necessary to determine if acceptable entry conditions are being maintained during the course of entry operations. This may include having entrants wear monitors.

   ix. If a hazardous atmosphere is detected during entry, all employees will be evacuated from the space and the entry permit will be canceled and the space re-evaluated.

g. Where ventilation is used to control the atmosphere in a confined space:

i. Ventilation equipment shall be directed at the immediate areas where employees will be present in the confined space.

ii. Source air shall be clean.

iii. Only electric fans shall be used and if the confined space has the potential for an explosive atmosphere, explosion proof ventilation shall be used.

iv. Fans shall be located outside of the confined space when feasible.

v. Egress shall not be impeded by ventilation equipment.

vi. Ventilate the space for at least 15 minutes prior to testing the atmosphere.
vii. Ventilation shall continue until the employee leaves the confined space.

h. Lockout/Tagout requirements will be implemented as indicated by LHH Lockout/Tagout Program.

i. When Workplace Safety staff or the Chief Engineer determine that PPE is required:
   i. Equipment shall be provided at no cost to the employee.
   ii. Respirators will be used as indicated by LHH Respiratory Protection Program.
   iii. Other personal protective equipment will be used as indicated by LHH Injury Illness Prevention Program or Personal Protective Equipment Program.

5. Emergency Response

a. The local Fire Department is the designated emergency entry rescue service.

b. LHH employees are not authorized and shall not perform entry rescue if hazards cannot be controlled or eliminated prior to entry.

c. Emergency rescue procedures shall be reviewed prior to each PERMIT REQUIRED entry.

d. The attendant shall establish communication with the Facility Services Supervisor prior to entry in case the emergency entry rescue service (Fire Department) must be summoned.

e. Attendant will be present and responsible for maintaining communication with entrants, monitoring conditions in and out of confined space, preventing unauthorized entry, ordering an evacuation, and initiating emergency procedures.

f. Entrants will initiate self-rescue if conditions change such as the gas monitor alarm has been activated.

 g. The attendant will initiate non-entry rescue and contact the Facility Services Supervisor if entrants are unable to perform self-rescue.

h. If non-entry rescue does not work, the Facility Services Supervisor will inform the Fire Department of the hazards they may confront so they can equip and conduct themselves appropriately and assist where needed.

6. Hot Work Permit

A hot work permit (Appendix E) must be completed by Workplace Safety staff, the Chief Engineer, or designee before any of the following work procedures are to be performed in any confined space:

- Welding
- Cutting
- Heating
- Any procedure that may produce a source of ignition
REFERENCES:

73-01 Laguna Honda Injury and Illness Prevention Program

ATTACHMENTS:

Appendix A: List of Confined Spaces
Appendix B: Confined Space Classification Flow Chart
Appendix C: Laguna Honda Confined Space Pre–Entry Safety Checklist
Appendix D: Laguna Honda Confined Space Entry Permit
Appendix E: Hot Work Permit

Most recent review:
Revised:
Original adoption: 16/xx/xx
## Appendix A: List of Confined Space Access Point at Laguna Honda

<table>
<thead>
<tr>
<th>Building</th>
<th>Access point Number</th>
<th>Description of Space</th>
<th>Access Point Location(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin</td>
<td>A1</td>
<td>A wing basement crawlspace</td>
<td>End of A Wing inside exit stairwell</td>
</tr>
<tr>
<td>Admin</td>
<td>A2</td>
<td>Mechanical room under stage</td>
<td>Under stage in Simon theater</td>
</tr>
<tr>
<td>Admin</td>
<td>A3</td>
<td>A wing crawlspace</td>
<td>Hatch @ bottom of stairs to SFSD office</td>
</tr>
<tr>
<td>Admin</td>
<td>A4</td>
<td>Simon Theater crawlspace</td>
<td>Wall Hatch @ bottom of stair 1</td>
</tr>
<tr>
<td>Admin</td>
<td>A5</td>
<td>Main tunnel</td>
<td>1st Floor through boiler room</td>
</tr>
<tr>
<td>Admin</td>
<td>A6</td>
<td>Simon Theater crawlspace</td>
<td>5 Screens on exterior of H wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A7</td>
<td>Main tunnel</td>
<td>Floor Hatch outside D2</td>
</tr>
<tr>
<td>Admin</td>
<td>A8</td>
<td>Main tunnel</td>
<td>Wall Hatch outside D2</td>
</tr>
<tr>
<td>Admin</td>
<td>A9</td>
<td>Main tunnel</td>
<td>Hatch on Exterior by G wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A10</td>
<td>C wing crawlspace</td>
<td>C wing-Eastside Exterior door in sump pit</td>
</tr>
<tr>
<td>Admin</td>
<td>A11</td>
<td>C wing crawlspace</td>
<td>Wall hatch inside storage space at end of C wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A12</td>
<td>B wing crawlspace</td>
<td>B Wing Eastside – Exterior Space door in sump pit</td>
</tr>
<tr>
<td>Admin</td>
<td>A13</td>
<td>B wing crawlspace</td>
<td>Wall Hatch inside COPC clinic shop</td>
</tr>
<tr>
<td>Admin</td>
<td>A14</td>
<td>D wing crawlspace</td>
<td>D Wing - Exterior Space door in sump pit</td>
</tr>
<tr>
<td>Admin</td>
<td>A15</td>
<td>E wing crawlspace</td>
<td>Exterior Hatch Westside E wing towards main spine</td>
</tr>
<tr>
<td>Admin</td>
<td>A16</td>
<td>E wing crawlspace</td>
<td>Wall Hatch at the bottom of E Wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A17</td>
<td>E wing crawlspace</td>
<td>E Wing - Exterior Space door in sump pit</td>
</tr>
<tr>
<td>Admin</td>
<td>A18</td>
<td>K wing crawlspace</td>
<td>Access grate in ground</td>
</tr>
<tr>
<td>Admin</td>
<td>A19</td>
<td>K wing crawlspace</td>
<td>Access grate in ground</td>
</tr>
<tr>
<td>Admin</td>
<td>A20</td>
<td>K wing crawlspace</td>
<td>K wing- Eastside</td>
</tr>
<tr>
<td>Admin</td>
<td>A21</td>
<td>M wing crawlspace</td>
<td>Exterior hatch at end of M Wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A22</td>
<td>M wing crawlspace</td>
<td>Wall hatch to hot H20 tank</td>
</tr>
<tr>
<td>Admin</td>
<td>A23</td>
<td>Main tunnel</td>
<td>Floor hatch inside M3 mechanical room</td>
</tr>
<tr>
<td>Admin</td>
<td>A24</td>
<td>Main tunnel</td>
<td>Wall hatch at end of corridor 3rd floor</td>
</tr>
<tr>
<td>Admin</td>
<td>A25</td>
<td>Boneyard crawlspace</td>
<td>Door in rear of boneyard</td>
</tr>
<tr>
<td>Admin</td>
<td>A26</td>
<td>Boneyard</td>
<td>4th floor end of corridor between M&amp;O wings</td>
</tr>
<tr>
<td>Admin</td>
<td>A27</td>
<td>Load center C</td>
<td>Vault in O3 mechanical space</td>
</tr>
<tr>
<td>Admin</td>
<td>A28</td>
<td>O wing crawlspace</td>
<td>Wall hatch to hot h20 tank</td>
</tr>
<tr>
<td>Admin</td>
<td>A29</td>
<td>Main water supply valve pit</td>
<td>Valve pit in O4 East side patio area</td>
</tr>
<tr>
<td>Admin</td>
<td>A30</td>
<td>O wing crawlspace</td>
<td>Exterior Hatch at end of O wing</td>
</tr>
<tr>
<td>Admin</td>
<td>A31</td>
<td>L wing crawlspace</td>
<td>Access grate in ground</td>
</tr>
<tr>
<td>Admin</td>
<td>A32</td>
<td>L wing crawlspace</td>
<td>Access gate in ground</td>
</tr>
<tr>
<td>Admin</td>
<td>A33</td>
<td>Main tunnel</td>
<td>Steam tunnel access at bottom Stairwell</td>
</tr>
<tr>
<td>Admin</td>
<td>A34</td>
<td>F wing crawlspace</td>
<td>F wing exterior door in sump pit</td>
</tr>
<tr>
<td>Location</td>
<td>Equipment/Room</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>H Bld</td>
<td>F wing crawlspace</td>
<td>Exterior hatch west side F wing</td>
<td></td>
</tr>
<tr>
<td>Link Building L1</td>
<td>Kitchen AHU</td>
<td>Roof of link building</td>
<td></td>
</tr>
<tr>
<td>Link Building L2</td>
<td>Café AHU</td>
<td>Roof of link building</td>
<td></td>
</tr>
<tr>
<td>Link Building L3</td>
<td>Pharmacy AHU</td>
<td>Roof of link building</td>
<td></td>
</tr>
<tr>
<td>Link Building L4</td>
<td>Gaylord hood system</td>
<td>Roof of link building</td>
<td></td>
</tr>
<tr>
<td>Pavilion P1</td>
<td>P1 crawl space</td>
<td>Back of clinic</td>
<td></td>
</tr>
<tr>
<td>Pavilion P2</td>
<td>PM crawl space</td>
<td>Behind PMA Nurses' station</td>
<td></td>
</tr>
<tr>
<td>Pavilion P3</td>
<td>2 AHUs and IDECS</td>
<td>Pavilion roof</td>
<td></td>
</tr>
<tr>
<td>Pavilion P4</td>
<td>Kitchen dumbwaiter</td>
<td>Kitchen and cafeteria</td>
<td></td>
</tr>
<tr>
<td>Pavilion P5</td>
<td>Mezzanine mechanical room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pavilion P6</td>
<td>Pool AHU #6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Tower S1</td>
<td>2 AHUs and IDECS</td>
<td>South tower roof</td>
<td></td>
</tr>
<tr>
<td>South Tower S2</td>
<td>2 boilers</td>
<td>South tower boiler room</td>
<td></td>
</tr>
<tr>
<td>South Tower S3</td>
<td>Hot water storage tank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Tower S4</td>
<td>Heating hot water tank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Tower S5</td>
<td>Linen chute</td>
<td>Soiled linen room on each floor</td>
<td></td>
</tr>
<tr>
<td>North Tower N1</td>
<td>2 AHUs</td>
<td>North tower roof</td>
<td></td>
</tr>
<tr>
<td>North Tower N2</td>
<td>2 loading dock lifts</td>
<td>North loading dock</td>
<td></td>
</tr>
<tr>
<td>North Tower N3</td>
<td>Linen chute</td>
<td>Soiled linen room on each floor</td>
<td></td>
</tr>
<tr>
<td>Grounds G1</td>
<td>Vaults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grounds G2</td>
<td>Cistern</td>
<td>Horseshoe parking area</td>
<td></td>
</tr>
<tr>
<td>Grounds G3</td>
<td>Grease trap tank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grounds G4</td>
<td>4 USTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grounds G5</td>
<td>1 Above ground fuel tank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grounds G6</td>
<td>Old generator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grounds G7</td>
<td>2 Water tanks</td>
<td>Hill behind east parking lot</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B:
Confined Space Classification Flow Chart

Is it a Confined Space?
It is if all 3 criteria are present.
- It is large enough to enter and perform work.
- It has limited means of entry and exit.
- It is not designed for continuous human occupancy.

NO

Confined Space Procedure not required.

YES

Are any hazards present?
- Atmospheric
- Engulfment
- Entrapment
- Any serious safety hazard

NO

Can the hazards be controlled or eliminated?

NO

Use Non-Permit Confined Space Procedures.

YES

Use the Permit Entry Procedures

NO

Use Modified Entry Procedures

YES
Appendix C:
Laguna Honda Confined Space Pre-Entry Safety Checklist

Instructions: THIS FORM MUST BE COMPLETED BEFORE EVERY ENTRY INTO A NON PERMIT CONFINED SPACE. Complete the form and notify a Facility Services Supervisor before prior to entry. Maintain this record in LHH CONFINED SPACE LOG binder in the Facility Services Office.

<table>
<thead>
<tr>
<th>ENTRANT SECTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>Name of Entrant(s)</td>
<td></td>
</tr>
<tr>
<td>Description of intended work tasks</td>
<td></td>
</tr>
<tr>
<td>Area to be entered</td>
<td></td>
</tr>
<tr>
<td>Entry Access Point</td>
<td></td>
</tr>
</tbody>
</table>

Will chemicals such as glues or paints be used inside the space?  Y  N
Will “hot work” (welding, cutting etc.) be performed, or the use of any equipment that may introduce a source of ignition inside the space?  Y  N
Is heavy equipment such as generators, tractors, backhoes, forklifts, trucks or cars operating near the space -- that may create an oxygen-deficient environment?  Y  N
Is there evidence of engulfment hazards such as water, soil, or sewage inside the space?  Y  N
Is there plant debris or decaying animal matter inside the space that can create a hydrogen sulfide exposure hazard?  Y  N
Is there evidence of toxic air contaminants inside the space?  Y  N
Is any other hazardous condition present or probable to develop while inside the space?  Y  N

If you answered YES to any of the above questions:
Do not enter the space and report to a supervisor for further instruction.
If you answered NO to all of the above questions, ask your Supervisor to complete the sections below.

<table>
<thead>
<tr>
<th>SUPERVISOR SECTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities Services Supervisor</td>
<td></td>
</tr>
<tr>
<td>PRINT NAME</td>
<td>SIGN NAME /DATE/TIME</td>
</tr>
</tbody>
</table>

Will the entrant be working alone?  YES  NO
What is the estimated length of entry  _______ mins
Do any systems require lockout?  YES  NO  Specify:

Recommended Personal Protective Equipment:
- Respirator (consult Industrial Hygienist)
- Fire Extinguisher
- First Aid Kit
- Barricades, Signs, Cones
- Hearing Protection
- Gloves
- Coveralls
- Access Ladder
- Safety Glasses
- Face Shield & Goggles
- Hardhat
- Safety Shoes/Boots
- Other _______________________

<table>
<thead>
<tr>
<th>SAFETY SECTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection Findings:</td>
<td></td>
</tr>
<tr>
<td>Status of Space: (Circle One)</td>
<td>Non-Permit  Permit Required</td>
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Appendix D:

Laguna Honda Confined Space Entry Permit

Permit valid for one entry and one work shift only.
Start Date & Time: __________________________    End Date & Time: __________________________
Location and ID of Permit Space: __________________________
Reason for Entry (Description of Work): __________________________

List of Materials/Chemicals in or brought into space: (attach all SDSs)

List of equipment in or brought into space:

Entry Supervisor: __________________________
Entry Personnel: __________________________
Attendant(s): __________________________

Pre-Entry Atmospheric Testing:
Date: __________    Time: __________
Oxygen: ________%    Other Toxic Gas/Vapor: __________    ______ ppm
LEL: ________%    Other Toxic Gas/Vapor: __________    ______ ppm

Acceptable Entry Conditions:        % O2: 19.5-23.5%
% LEL: <10%
Other toxic gases/vapors: consult IH

Signature of person completing testing: __________________________
Hazards Identified

- Oxygen deficiency (less than 19.5 %)
- Oxygen over 23.5 %
- Flammable gases/vapors (at or above 10% of the lower explosive limit (LEL))
- Toxic gases/vapors (from materials in space or chemicals to be used in space)
- HOT WORK (requires additional precautions)
- Electrical

- Mechanical
- Slippy Surface
- Vertical Drop/Falls
- Low or High Temperature
- Interior Slope
- Low Overhead
- Engulfment
- Other (specify): ____________________

Isolation/Lockout-Tagout/Controls

- Cleaned, drained, washed & purged
- Electrical Lock-out/Tag-out Completed LIST
- Mechanical LOTO Completed LIST
- Pneumatic LOTO Completed LIST
- Ventilation (specify method) – Natural or Mechanical (electric powered or gasoline powered)
- Coordination with Contractor Completed

Equipment Required

<table>
<thead>
<tr>
<th>Personal Protective Equipment</th>
<th>Safety Equipment</th>
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<tr>
<td>Safety Glasses</td>
<td>Gas Meter</td>
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<tr>
<td>Goggles</td>
<td>Full Body Harness and Lifeline</td>
</tr>
<tr>
<td>Face Shield &amp; Goggles</td>
<td>Personal Distress Device (each person)</td>
</tr>
<tr>
<td>Coverall</td>
<td>Tripod w/ Mechanical Retrieval Device</td>
</tr>
<tr>
<td>Hardhat</td>
<td>Two way Radio</td>
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<tr>
<td>Gloves</td>
<td>Fire Extinguisher</td>
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<tr>
<td>Safety Shoes/Boots</td>
<td>First Aid Kit</td>
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<tr>
<td>Respirator</td>
<td>Barricades, Signs, Cones</td>
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<tr>
<td></td>
<td>Ground Fault Circuit Interrupters</td>
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<tr>
<td>10 minute Escape Pack</td>
<td>Lighting/Explosion Proof Flashlight</td>
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<tr>
<td>Hearing Protection</td>
<td>Access Ladder</td>
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<tr>
<td>Other</td>
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</table>
Emergency/Rescue Procedures

a. Do not enter the confined space to rescue entrants.
b. Contact Supervisor, dial 911 if no response.
c. Keep one employee present outside the space to monitor the rescue effort, and direct the Fire Department to the victim(s).
d. If the victim(s) can be removed by the hoisting device, provide CPR and First Aid as necessary until emergency response personnel arrive.

Pre-Entry Safety Briefing Held (List all Entrants, Standby, Supervisors, etc)

<table>
<thead>
<tr>
<th>Name</th>
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Periodic Atmospheric Testing: Initials ______

<table>
<thead>
<tr>
<th>Detector</th>
<th>Time</th>
<th>Location</th>
<th>% Oxygen</th>
<th>%LEL</th>
<th>Potential Toxic Gases/Vapors</th>
<th>Conc. (ppm)</th>
<th>Initial</th>
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Acceptable Entry Conditions: % O2: 19.5-23.5%
% LEL: <10%
Other toxic gases/vapors: consult IH

Workplace Safety /Chief Engineer or Designee Authorization:
I certify that required precautions have been taken & necessary equipment is provided for confined space entry.

Print Name __________________________ Signature __________________________ Date & Time __________________________
Appendix E: Hot Work Permit
LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER
SUBSTANCE TREATMENT AND RECOVERY SERVICES (LHH STARS)

POLICY:
Laguna Honda Hospital and Rehabilitation Center (LHH) provides substance treatment and recovery services (LHH STARS) for its residents with substance use service needs. These services comply with medical necessity criteria that are in alignment with San Francisco Health Network Behavioral Health Services (SFHN-BHS) and Medicare/MediCal standards.

PURPOSE:
1. To establish Policies and Procedures through which LHH STARS clinicians deliver treatment services for LHH residents with substance use disorders (SUD).

2. To ensure that STARS clinical services are evidence-based, including the use of co-occurring service models, and are modeled after a Drug Medi-Cal Outpatient Drug-Free (ODF) Program, and meet SFHN-BHS requirements.

3. To ensure that the results of such treatment are meaningful, useful and communicated where appropriate to the attending physician or the referral party.

OVERVIEW:
LHH STARS program is part of LHH Psychiatry, which is a Clinical Service under LHH Medical Staff Services. The STARS program provides outpatient substance use treatment to residents of LHH. STARS services are modeled after the regulatory guidelines of Drug-Medi-Cal (DMC), SFHN-BHS of San Francisco Department of Public Health, and The Department of Health Care Services of California (DHCS).

Substance use treatment services (including screening, assessment, treatment planning, individual and group counseling services) and other substance recovery related services are provided by a team of LHH staff who are registered, licensed, or certified to provide substance use and/or mental health services in California. These services are provided under the direction of STARS Medical Director (or designee) and coordinated on a day-to-day basis by the STARS Clinical Coordinator.

PHILOSOPHY:

All STARS services are provided in alignment with the SFHN-BHS philosophy of care; elements include but are not limited to:

- Client centered
- Evidence based
- Strength based
- Individually tailored
- Trauma-informed
- Culturally sensitive
- Promoting autonomy, optimism and hope
- Integrating care for bio-psycho-social-spiritual aspects of the whole person.

**PROCEDURE:**

The practice procedures outlined below are the general service delivery process of LH STARS. Staff will follow the steps as they are implemented during the program development process.

1. **Referral**
   
   a. Any LHH residents with known, suspected, unresolved or history of substance use with or without treatment that may meet DSM-5 criteria for a substance use disorder diagnosis, (excluding nicotine-only) may be referred by LHH Primary Physician for substance use disorder screening and/or treatment services via the E-referral process for LHH Psychiatry.
   
   b. Any LHH resident and/or family can request a STARS screening/assessment for the resident. The resident and/or family notifies the resident’s primary physician who enters the request into an E-referral.
   
   c. Designated LHH Psychiatry triage staff will review the referral within one business day of the E-referral entry. Any referrals where substance use is a clinical concern will be assigned to a STARS clinician for screening.
   
   d. The referring physician will be notified within two business days of receiving the e-referral by the assigned STARS clinician.
   
   e. The assigned clinician will review the resident’s medical record and complete a screening within five (5) business days after being assigned, sooner if clinically indicated, unless the residents’ special medical or other conditions warrants otherwise (the reasons for delayed screening and assessments need to be documented in the e-referral response and the electronic health record (EHR) designated for LHH STARS.

2. **Information Gathering**
   
   a. The assigned clinician will collect information from medical records, staff, the LHH primary physician, and other entities authorized by the resident.
   
   b. The clinician will screen the following areas:
      
      i. The resident’s history of using one or more substances (excluding nicotine-only) including prescription medication or medical cannabis, with such use meeting criteria for a DSM-5 substance use disorder diagnosis. This may
include mild use disorders as well as substance use disorder in remission if he/she is at risk for relapse without outpatient treatment.

ii. Motivation for Treatment (stages of change model).

iii. Physical and cognitive capacity to participate and benefit from receiving substance treatment.

c. Until the resident is diagnosed with a substance use disorder and agrees to treatment, all initial documentation will be entered into the EHR designated for either LHH specialty mental health services or LHH non-specialty mental health and primary care behavioral health services.

d. For residents who decline to participate in the STARS program during the initial encounter:

i. The clinician shall explain to the resident, that he/she can request to be re-assessed and admitted to the STARS program at any time during their LHH stay.

ii. The clinician will leave his/her contact information and STARS related program materials with the resident.

iii. The STARS clinician will make at least one more attempt based on his/her clinical judgment to engage the resident in STARS program through outreach efforts and other non-treatment recovery programming.

iv. The STARS clinician must notify the referring primary physician and STARS Clinical Coordinator regarding the residents’ decision not to participate in the STARS program. The STARS clinician must document the communication.

3. Admission to STARS program

a. Inclusion Criteria:

i. The resident meets criteria for a DSM-5 Substance Use Disorder diagnosis (including in sustained remission), excluding nicotine only.

ii. The resident is interested in, or ambivalent but willing to participate in, the STARS program.

iii. The resident has the basic cognitive and physical capacity to participate in and benefit from treatment.

b. Once admitted to the STARS program, the resident must be opened in the designated EHR for LHH STARS.
c. For residents who are admitted to the STARS program, the STARS clinician will:

i. Complete an Intake assessment (this may be extended over multiple sessions if preferred by the resident).

ii. Complete necessary treatment consent and Authorization to Disclose Private Health Information (see 11. below)

iii. Have the STARS Medical Director (or designee) review the physical exam (must be within the past 12 months), the screening and Intake Assessment by the STARS clinician.

iv. Have the STARS Medical Director (or designee) review and approve (as indicated) the DSM-5 diagnosis (es) and medical necessity of admission.

4. STARS Treatment Plan of Care

a. Upon completion of the Intake Assessment, the primary STARS clinician shall develop a Treatment Plan of Care with the resident, as per DMC requirements.

i. This must be completed and signed by the STARS clinician, physician, and resident within 30 days of admission (with the physician signature no later than 15 days after the clinician signature, and within 30 days of admission).

b. The resident’s assessment and preliminary plan are presented at the next STARS Team Meeting for review and comment.

c. The treatment plan is finalized, reviewed and approved by the resident and then reviewed and approved by the STARS Medical Director (or designee).

d. Treatment plan reviews will be documented every 30 days. New treatment plans must be completed every 90 days per DMC requirements.

i. New treatment plans are not necessarily brought to the STARS treatment team but every treatment plan must be signed by the STARS Medical Director (or designee MD) within 15 days of the treatment plan date and clinicians’ signature.

ii. Changes to the plan must also be signed by the resident.

e. The treatment plan is developed using person-centered principles.

5. Substance Use Treatment

a. The substance use treatment modalities at LHH include:

i. STARS admission and intake assessment and reassessment
ii. person-centered treatment planning and treatment plan reviews  
iii. individual, group (and when appropriate couples or family) therapy and psychoeducation  
iv. crisis intervention  
v. collateral sessions (meetings with family or others in the resident's natural support network)  
vi. medication support and management  
vii. coordination with hospital-based case management (RCT and medical social worker), including assistance with discharge planning and developing community-based substance use recovery plans. (See LHH HWPP 20.04 Discharge Planning)

b. All services are to be provided with a wellness recovery approach.

6. Documentation

a. Documentation of LHH STARS services will be completed in the designated EHR. Paper records including the resident’s signature will be kept in a separate STARS medical record. Upon the resident’s discharge from LHH, such records will be forwarded to SFHN-BHS Medical Record.

b. All documentation will follow the most current instructions for documentation, including but not limited to timing and content, based on the current Community Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual. Provision of the instructions is the joint responsibility of the STARS Medical Director (or designee) and the Clinical Coordinator.

7. Other Substance Use Recovery Related Groups and Activities

a. In addition to treatment services, LHH STARS program will also include outreach, engagement and educational services for the general resident population and for those who are not ready to commit to active treatment. These services are focused on reduction of active use and harm.

b. STARS outreach program will also include peer support services such as AA, NA, LifeRing Secular Recovery, and others.

i. Appropriate approval and clearance by the LHH Chief Medical Officer must be obtained before such groups may start.

ii. Coordination of these groups and activities will be through the LHH STARS Clinical Coordinator.

iii. Information about participation in peer support services for admitted residents will be collected from the resident during individual and/or group sessions. This information will be documented by STARS clinicians in individual and/or group counseling progress notes.
8. Inclusion of Clients Who are Not Laguna Honda Residents
   a. With the approval of the STARS Medical Director, former residents who do not have reasonable access to outpatient services once they have been discharged from LHH will be allowed to continue to attend STARS groups.
   b. This will be time-limited while other service options are being explored.
   c. If a group/activity has limited space, LHH residents have priorities over those who are not LHH residents.

9. Active Use, Contraband and Searches for Illicit Drugs and Paraphernalia
   a. STARS clinicians staff are NOT to participate in any clinical searches for the purpose of maintaining milieu safety.
   b. LH STARS clinicians may participate in general discussions to address illicit drug use, either hospital wide and/or with the RCT.
   b-c. For residents with behavioral issues related to active use and negatively impacting care, STARS clinicians will collaborate with the RCT on behavioral management services. See LHH MSPP D08-10 Behavioral Management Services by LHH Psychiatry.

10. Education about Substance Use Treatment
    a. All LH STARS clinicians have a role in helping the RCT, family members and/or the general resident population at LHH to learn about substance use disorders, wellness and recovery principles, and the DPH harm reduction policy.
    b. The purpose is to reduce stigma, promote greater understanding of these disorders and potential consequences, and to increase the skills of staff and family especially in participating in treatment planning and helping to promote recovery.
    c. Such educational activities may include but are not limited to: staff training, family psychoeducation, consultation to the RCTs for specific residents, Learning Circles, and other means for increasing and improving understanding and knowledge about substance use disorders.

11. Privacy and Authorization to Disclose Substance Treatment Information
    a. LHH STARS will follow federal and state laws that cover the disclosure and re-disclosure of substance use treatment information.
b. LHH provides team based services and the Resident Care Team concept is central to LHH’s holistic approach to care. Communication between the Resident Care Team (RCT) and the STARS staff is critical to this process.

c. Resident rights, privacy practices and grievance procedures are covered at the LH admission intake prior to the STARS intake assessment.

c. In order to facilitate care coordination, whenever appropriate, e.g. during pre-admission behavioral screening, at the LHH admission intake, or during interaction with the resident, any LHH provider(s) (and/or STARS provider, Psychiatry provider or RCT members) may upon admission to the STARS program, ask the resident will be asked to sign the DPH an “Authorization to Disclose Protected Health Information for Care Coordination Purposes Form:” indicating authorization for the resident’s substance use treatment information to be disclosed to the RCT members. The form shall indicate specifically if the resident is authorizing verbal disclosure of treatment information, release of written substance treatment documentation, or both. The signed form will be filed in the resident’s STARS chart, with a copy placed in the resident’s unit chart under “Consent.”

d. Providers are encouraged to explain to the resident the importance of care coordination, while understanding that authorizing disclosure of substance treatment information is voluntary, and that the residents have the right to revoke the authorization, verbally or in writing, at any time. Minimum necessary requirements of HIPPA will be followed.

e. Recipients of such disclosed substance treatment information are responsible for complying with legal requirement to refrain from re-disclosing substance treatment Consent to disclose substance treatment medical record information except with the resident’s written authorization or as specifically required by law.

e.f. As LHH STARS is part of the comprehensive behavioral health program of LHH Psychiatry, and LHH Psychiatry providers provide clinical cross-coverage for each other, a resident’s STARS provider may share the resident’s substance treatment information with other LHH Psychiatry providers. Minimum necessary requirements of HIPPA will be followed. The resident must sign LH Authorization to Release Protected Health Information Form, and specify the substance treatment medical record in order for STARS clinician to release any written documentation.

ATTACHMENT:

REFERENCE:
1. 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By Residents or Visitors

2. Community Behavioral Health Services Substance Use Disorders Comprehensive Documentation Manual, 2015

3. MSPP D08-03 Access to LHH Psychiatry Services
4. MSPP D08-10 Behavioral Management Services by LHH Psychiatry.

2-5. HWPP 20-04 Discharge Planning

Most recent review: 2016/02/11 (Year/Month/Day)
Revised: 2016/11/03, 2017/01/10
Original adoption: 2016/02/04
ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (LHH) regardless of race, color, creed, religion, national origin, ancestry, gender, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age over 16. LHH will comply with California and federal laws pertaining to non-discrimination.

1. LHH will accept and care for those San Francisco residents:
   a. who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation (inpatient rehabilitation facility (IRF) care criteria;
   b. for whom it can provide safe and adequate care; and/or
   c. who are at least 16 years of age.

2. Applicants for admission to LHH shall be screened prior to any admission.

3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether each resident’s care environment is best able to meet these needs.

4. LHH will accept pre-scheduled admissions of new and returning patients Monday through Friday.

5. New and returning patients from Zuckerberg San Francisco General Hospital (ZSFG) may also be admitted on Sundays if pre-arranged on Friday. Returning patients from UCSF may also be readmitted on Sundays if pre-arranged on Friday.

6. LHH shall centrally coordinate resident relocations to:
   a. optimize utilization of resources;
   b. optimize bed availability for new admissions; and
   c. minimize the potential for adverse impact on the resident.

7. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

8. In case of emergency and/or medical surge conditions:
   a. Physician may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.
b. The patient's stay shall be documented according to established procedures (i.e. Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.

2. To allocate services in coordination with available hospital resources.

3. To provide a standard procedure for relocation of residents within the facility.

ABBREVIATION:

1. A&E: Admissions and Eligibility Department

2. PFC: Patient Flow Coordinator

3. RCT: Resident Care Team

PROCEDURE:

1. Admissibility and Screening Procedures

   a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Executive AdministratorChief Executive Officer (CEO)/Designee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.

   b. The LHH Medical DirectorChief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH Executive AdministratorCMO is the ultimate authority over admissions. The following sequential priority will be followed unless the LHH Executive AdministratorCMO or designee in his/her professional judgment, based on risk assessment and the totality of circumstances consistent with the patient's best interest determines otherwise.

   c. People are accepted to LHH with the following priority guidelines:

      i. 1st Priority:
Persons not in a medical facility, as well as persons who are wards of the
Public Guardian or clients of Adult Protective Services, who cannot receive
adequate care in the present circumstances.

ii. 2nd Priority:
Patients at ZSFG ready for discharge to SNF level of care.

iii. 3rd Priority:
Persons not in a medical facility who are receiving adequate care in their
present circumstances.

iv. 4th Priority:
Patients at other San Francisco medical facilities.

v. 5th Priority:
Patients who are San Francisco residents presently in a medical facility or
private circumstance outside of San Francisco.

d. LHH cannot adequately care for prospective residents with the following:

i. communicable diseases for which isolation rooms are unavailable

ii. in police custody unless approved by CMO, CEO, Chief Nursing Officer
(CNO) or designees.

iii. ventilator

iv. medical problem requiring Intensive Care Unit care

v. primary psychiatric diagnosis without coexisting dementia or other medical
diagnosis requiring SNF or acute care

vi. highly restrictive restraints

vii. significant likelihood of unmanageable behavior endangering the safety or
health of another resident, such as:

• actively suicidal

• violent or assaultive behavior

• criminal behavior including but not limited to possession of weapons, drug
trafficking, possession or use of illegal drugs or drug paraphernalia

• sexual predation
• elopement or wandering not confinable with available elopement protections

• applicants who will not sign the smoke free preadmission agreement

e. Screening of applicants:

i. The Screening Committee which includes the following: Medical Director CMO or designee, Chief Nursing Officer CNO or designee, Admissions Coordinator, Patient Flow Coordinator and other members as designated by the Administrator, is responsible for screening referrals to LHH and accepting residents for admission.

ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Hospice) will be screened and accepted by the unit screening physician or screener.

iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the Medical Director CMO or designee, and the Chief Nursing Officer CNO or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have significant psychiatric, behavioral and substance use histories and/or current behavioral issues or psychiatric problems.

iv-v. Refer to Procedure 2 a. i. through vi. of LHHPP File: 72-01 Infection Control Manual C26 Guidelines for Prevention and Control of Tuberculosis when screening new admissions to SNF services for tuberculosis.

f. Admission of applicants:

i. LHH shall admit a patient only on a LHH Admitting Physician’s order.

ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.

iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident’s individual needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. ¹Residents

¹ If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each residents’ individual needs and preferences rather than for staff convenience, and as long as the resident,
lacking capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.

iv. In all cases of admission from another facility, a physician to physician clinical hand off and a dictated discharge summary is required.

g. Resolution of problem screening and admissions:

i. Problems shall be brought to the LHH Medical Director CMO and LHH Executive Administrator CEO for resolution.

ii. The LHH Executive Administrator shall have the final authority over admissions to LHH.

h. The LHH Executive Committee CEO will serve as the Hospital’s review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices will be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

a. Pre-Admission Procedures

i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.

ii. Residents (or their representatives) will receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement will be reviewed and signed by the resident or the resident’s surrogate decision-maker.

iii. Residents (or their representatives) will receive a copy of House Rules and Responsibilities and Smoke-Free Campus Pre-Admission Agreement. As a condition of admission, the resident or resident’s surrogate decision-maker must agree to these conditions by signing these agreements before admission.

iv. The Screening Committee will make placement decisions based on the identified physical, mental, social and emotional needs of the resident, family connection with staff; if any; and bed availability and communicate with the surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident’s needs and preferences.” CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).
nursing unit and Resident Care Team including the primary physician and nurse manager admitting the new resident.

v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until the Admissions Coordinator has evaluated the referral packet.

vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit

i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.

ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.

iii. SNF residents who require blood transfusions, but who are not acutely ill, shall be provided on the Acute Medical Unit as “come and go” cases.

Procedures Specific to the Acute Medical Unit

i. All residents admitted to the Acute Medical Unit, except those residents admitted on a “come and go” basis, shall have a separate complete medical record covering the period of their acute hospitalization.

ii. Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, she/he is discharged from the previous care unit and resident’s medical record is closed, except in those cases where residents “come and go” for transfusion.

iii. A new SNF resident record will be started upon the resident’s re-admission to a SNF care unit.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units

i. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.
ii. Patient must be medically stable.

iii. Patient requires rehabilitation physician management.

iv. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:

- Training in bowel and bladder management
- Training in self care
- Training or instruction in safety precautions
- Cognitive function training
- Behavioral modification and management
- Training in communication

Admission Criteria Specific to Acute Rehabilitation Unit

i. The Laguna Honda Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF)

ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

- Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation
- 24 hour availability of nurses skilled in rehabilitation
- Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.

iii. The medical and/or surgical stability and comorbities of patients admitted to the unit must be:

- Manageable in the rehabilitation program
- Permit participation in the rehabilitation program

iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:

- Ability to respond to verbal, visual and/or tactile stimuli and to follow commands
- Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week)

v. Patients must demonstrate the ability to progress towards objective and measurable functional goals that:

- Will offer practical and beneficial improvements
- Are expected to be achieved within a reasonable period of time
  
vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.

vii. Patients in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

**Admission Criteria Specific to SNF Rehabilitation Unit**

i. Rehabilitation needs will include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.

ii. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a long term care unit.

**Admission Procedures Specific to Acute Rehabilitation Unit**

i. A physiatrist or designee will perform pre-admission screening (PAS) to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.

ii. A new SNF record will be started if the patient is discharged to a LHH SNF Care Unit.

iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation HWPP

**Admission Procedures specific to SNF Rehabilitation Unit**

i. The Chief of Rehabilitation Services/designee will perform pre-admission screening to assess the patient’s ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

ii. The Chief of Rehabilitation Services/designee will perform pre-admission screening to assess the patient’s ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

**d. Positive Care Unit**

**Admission Criteria Specific to the Positive Care Unit**

i. Patients who have HIV infection and require SNF level or palliative care and prefer an HIV / AIDS focused unit.
e. Hospice and Palliative Care Unit

**Admission Criteria Specific to Hospice and Palliative Care Unit**

i. Patients who have a terminal disease or would benefit from a palliative approach (see Medical Staff P & P Hospice and Palliative Care).

f. Secure Memory Care Unit

**Policies Specific to Secure Memory Care Unit**

i. The goals of the Secure Memory Care Unit are:
   - to promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and
   - to meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming while minimizing the use of individual restraints.

**Admission Criteria Specific to Secure Memory Care Unit**

i. Residents who are mobile;

ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for him/herself;

iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and

iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

v. The requirements above do not preclude LHH from placing a resident in the memory care unit on an emergency basis to ensure the resident’s safety but the placement must be authorized by the Medical Director.

**Exclusion Criteria Specific to Secure Memory Care Unit**

i. Residents whose aggressive behavior cannot be safely managed in this setting.

ii. Residents without surrogate or conservator.
Procedures Specific to Secure Memory Care Unit

i. The Admissions Coordinator and Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Unit RCT.

ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

iii. The RCT will reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT will explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT will document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.

iv. A resident of the LHH Secure Memory Care Unit will be relocated as soon as reasonably possible to other LHH units or transferred to another facility or the community if the resident’s status changes such that the resident is no longer mobile, the resident’s cognitive status improves such that secured placement no longer is needed; or the resident’s cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.

v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts should be made to adapt such a resident to another unit.

3. Sunday Admissions

a. From ZSFG

i. LHH primary physician will refer ZSFG team to LHH Admissions and Eligibility (A&E) once patient is accepted.

ii. Pre-scheduled admissions will be accepted for Hospice, Positive Care, General SNF, SNF and Acute Rehab (IRF) patients on Sundays.

iii. Sunday admissions from ZSFG must be approved by the LHH admissions screening committee, and accepted by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.
iv. LHH A&E will inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for Sunday. LHH A&E will inform ZSFG MSW of LHH primary physician's pager number.

v. Approval by LHH weekend admitting physician is not required for admission.

vi. LHH A&E will complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.

vii. LHH primary physician will receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a dictated discharge summary will be available at the time of admission.

viii. LHH nursing will receive report from ZSFG nursing on the day of transfer.

ix. LHH A&E will remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.

x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.

b. From UCSF

i. Only prearranged readmissions are accepted, as stated above.

4. Procedures Related to Coming and Going from the Hospital

a. Return of current residents after come-and-go procedures at other acute facilities.

   i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes.

      • procedures done;
      • complications, if any, both intra- and postoperative;
      • new orders recommended for the first 24 hours at LHH; and
      • recommendations for special studies and follow-up care.

   ii. A checklist reminding the responsible physician of the need for this information will be sent with the resident from LHH to the other facility. The
physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.

iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.

b. Bed hold definition: A bed hold is a bed held for a specific resident discharged to an acute unit or facility. A bed can be held up to seven (7) days, with the date of discharge being day 1. A bed hold cannot be placed on a bed on LHH acute units.

5. Relocation of Current Resident From One SNF Unit to Another SNF Unit

a. Relocation Guidelines

i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager will be responsible for explaining to the resident or surrogate decision maker (SDM) the process by which the RCT will assess the resident for the purpose of appropriate placement.

ii. Decision criteria. Criteria for determining the appropriate unit will be based on an assessment of the resident’s needs and knowledge of services available, including knowledge of available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units will be made by the PFC in collaboration with the Medical Director CMO or designee and Chief Nursing Officer CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.

iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT will be evaluated by the PFC who will facilitate the decision-making process.

iv. Relocation. In the event that a resident is to be relocated involuntarily in order to better match the resident’s needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. Notice shall include:

• reasons for the relocation;

• date the relocation will occur;
• the care unit to which the resident will be relocated; and
• the name, address, and phone number of the local ombudsman.

The RCT will take into consideration the resident’s response in deciding whether to continue with the relocation. This discussion must be documented in the medical record. In a contested relocation the medical social worker will inform the ombudsman.

v. **Problem resolution.** Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT will utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.

vi. **Re-evaluation of problematic relocations.** RCTs will re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.

vii. **Appeal route for conflict intervention.** Conflicts about relocation process will be referred to the Chief Nursing Officer (CNO) and Medical Director (CMO) for joint resolution.

viii. **Unit moves.** When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when residents and families will be informed, should be worked out in advance by an RCT.

b. Relocation Procedures

i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, will be routed through the designated PFC. For relocations to specialty units, the PFC will communicate with the unit RCT and A&E.

ii. The resident and appropriate family/surrogate decision maker(s) will be notified when the relocation is being planned and will be informed of the reason and the estimated waiting period, if known. They will be offered an opportunity to visit the new location, if possible.

iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician must communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.

iv. Once an appropriate bed becomes available, the PFC will confirm relocation plans and confirm that the sending and receiving care units are notified.

v. A physician’s order is required for the relocation.
vi. To promote continuity in care, the sending physician will document in the medical record, a relocation note.

vii. The receiving RCT will review the existing treatment plans initiated by the previous team, and review the plan and all changes with the resident.

viii. Each discipline shall take appropriate measures to assure continuity of care.

ix. Ancillary Service departments, who receive the Daily Census report, will make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 23-01 Development & Implementation of an Interdisciplinary Resident Care Plan
LHHPP 24-06 Resident Suggestions and Complaints
LHHPP File: 72-01 Infection Control Manual C26 Guidelines for Prevention and Control of Tuberculosis
Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

ATTACHMENT:
Appendix A: Relocation Checklist for Individual Resident

Revised: 00/07/13, 04/02/06, 04/03/02, 04/12/16, 09/08/24, 10/11/09, 11/01/25, 11/09/27, 12/01/31, 12/07/31, 13/11/21, 14/07/29, 14/11/25, 16/09/13, 17/01/10
(Year/Month/Day)
Original adoption: This is a consolidation of 12 previous policies
## Appendix A

### RELOCATION CHECKLIST FOR INDIVIDUAL RESIDENT

FROM CARE UNIT: _______________________

TO CARE UNIT: _______________________

DATE: __________________

ADDRESSOGRAPH: _________________________________________

### ITEMS CHECKED:

1. ADDRESSOGRAPH CARD
2. TRANSFER ORDER NOTED
3. ALLERGIES DOCUMENTED
4. IMMUNIZATIONS: PD □ dT □ PNEUMO □ FLU □
5. VITAL SIGNS
6. FAMILY AND/OR RESIDENT NOTIFICATION DOCUMENTED IN NURSING NOTES
7. PROGRESS NOTES
8. M.D.S.
9. RAP REVIEW & SUMMARY
10. RESIDENT CARE PLAN
11. MED / TX SHEETS & BEHAVIORAL MONITORING= SUMMARY □ TALLY SHEET □
12. ADL NOTES
13. ACTIVITY ATTENDANCE RECORD
14. CHRONOLOGICAL RECORD
15. SIGN CONSENT: PSYCH Rx □ RERAINT □ TUBE FEED □ dT □
16. ADAPTIVE DEVICE(S) SENT, Specify_____________________________________
17. SUMMARIZE RESTORATIVE NURSING PROGRAM:
18. PROPERTY: BEDSIDE □ SAFE □ BAGGAGE ROOM □
19. MEDICATIONS: MED CART □ TREAT CART □ FRIG □
20. SOCIAL SERVICE & DIETARY NOTIFIED
21. APPOINTMENTS:
22. OTHER INSTRUCTIONS:

CHECKED BY:
Appendix B

BEHAVIORAL SCREENING

1. Overview

- Referrals to LHH that have significant psychiatric, behavioral and substance abuse histories and/or current behavioral issues shall be screened by a LHH mental health professional.
- The primary behavioral screeners are mental health professional staff assigned by the Chief of Psychiatry or designee, and psychiatric social workers, backed by psychiatrists, psychologists and substance abuse treatment service (SATS) staff, who are available for consultations and screening as needed.
- The behavioral screener does not make admission decisions, but convey behavioral assessment information and recommendations about behavioral health service needs to the LHH Admissions Screening Committee, which has the final decision authority.

2. Responsibility of the Screener

- Conduct behavioral screening of certain LHH admission referrals.
- Follow status of referrals whose condition may be changing over time, as needed.
- Prepare a Screening Report that summarizes behavioral issues/problems and other potential risk factors, behavioral care plan approaches and their efficacy, with assessment conclusions of 1) whether the patient's behavioral health service needs can be met at LHH is considered behaviorally manageable at LHH, and 2) any clinical issues and management strategies the Resident Care Team (RCT) should be aware of, in the event should the patient is be admitted to LHH.
- Consult LHH Psychiatry providers psychiatrists, psychologists and substance abuse treatment service staff as needed, especially for patients who have previously been evaluated and/or treated by LHH Psychiatry psych/SATS providers at LHH.
- Consult LHH Chief of Psychiatry as needed on disputed cases.
- If the referred individual has potential need for behavioral health services (e.g. psychiatric medication management, substance use treatment, mental health services, behavioral consultation/planning), a substance abuse history, the behavioral screener will provide information on available services at LHH.
- If applicable, the screener will obtain a LHH Treatment Agreement for Treatment & Compliance with Hospital Regulations, which includes information about Substance Treatment and Recovery Services (STARS) at LHH, signed by the patient/resident and/or decision-maker, endorsing compliance and participation in SATS at LHH. (need to confirm this with Dr. Yifang Qian)
- Does not include making decisions about admissions.

3. Areas of Review
• Review the screening packet for background history plus contact information of most knowledgeable care-providers and surrogate decision-makers. Phone calls to these individuals may be helpful.

• Review EHR LCR and any current paper chart noting especially diagnoses, medications, conservatorship status (and any Affidavit A’s and Affidavit B’s), prior APS contact, recent progress notes, use of PRN medications, daily nursing flow sheet.

• Especially note records of current and prior history of aggression, self-harm, emotional lability, active psychotic symptoms, personality disorder, elopement risk, drug and alcohol use, (current and prior), history of criminality, fire-setting, predatory behaviors (sexual, aggressive, fiscal or other abuse), treatment non-compliance, and any other behavioral issues.

• Review prior and current behavioral management plans/techniques and their efficacy.

• When indicated, review current legal status, including whether the patient has any pending charges. The screener will check all behavioral referrals on the California Megan’s Law website (http://www.meganslaw.ca.gov/) and the national database (http://nsopw.gov) to verify whether the patient is a registered sex offender (RSO). If the patient is a RSO, request obtain from the referring agency the registration documentation and history information regarding the sexual offense status.

• Obtain copy of psychotropic medication consent when available if the patient is on psychotropic medications.

4. Screening Schedule and Communication

• Behavioral screening requests are sent to the behavioral screener Chief of Psychiatry/designee by a member of the Admission Committee verbally or in writing.

• The referral information packets are usually available from A&E a few days prior to screening.

• The behavioral screener will screen within one work day in general, or as soon as possible, but no later than within three work days unless otherwise arranged.

• The Screening Report will be documented in the designated Electronic Health Record (EHR) for LHH Psychiatry.

• The screener will forward the copy of the Screening Report to members of the LHH Admissions Screening Committee, Chief of Psychiatry/designee, as well as the admitting RCT if applicable.

• The LHH Admissions Screening Committee meets every Tuesday and Thursday, and as needed. A behavioral screener/designee will attend the meeting or be available by phone.

• The behavioral screener may be available to answer questions from the admitting RCT about screening information on the resident. Such information is for screening purposes only and does not substitute for the RCT members’ own clinical assessments.
5. High Behavioral Risk Admissions

Potentially high behavioral risk admissions will be identified by the behavioral screener, the Admissions Screening Committee and the admitting RCT if applicable.

Prior to Admission

- The behavioral screener will screen or re-evaluate the referred patient within one week of and before the admission date.
- The behavioral screener will brief the RCT and all LHH Psychiatry staff on potential behaviors and management recommendations prior to admission, include the behavioral plan, if any.
- Transfer/Discharge summary must be received by the admitting MD the day before the patient is transferred, and the sending MD must be available for phone sign out to the primary care physician and the LHH Psychiatry consultant.

Day of admission

- The admission should take place early in the week, Monday through Wednesday if possible.
- The admitting MD will make e-referral to LHH Psychiatry upon admission as indicated.
- The LHH Psychiatry assigned psych-consultant(s) will prioritize evaluating the resident upon receiving the e-referral.

After Admission

- The behavioral screener or assigned LHH Psychiatry consultant will do a follow up evaluation of the patient and discuss with RCT members within 24 hours of admission, or the next work day.
- The RCT will discuss the patient in unit huddle at least daily for the first week. The behavioral screener and/or the assigned LHH Psychiatry psych/SATS consultant(s) will attend when possible.

6. Returns and Re-admissions from PES/Inpatient Psychiatry

PES/Inpatient Psychiatry will contact the patient’s primary physician and assigned LHH Psychiatry consultant for returns and re-admissions. The behavioral screener/designee is available to assist with in-person evaluations as needed. The re-admission decision will be made by the primary physician in consultation with the
Psychiatry consultant. Disputed cases shall be referred to the Chief of Psychiatry and/or the Chief Medical Officer.
FALLS

POLICY:

Laguna Honda Hospital and Rehabilitation Center shall employ fall prevention strategies designed to minimize falls risk by ameliorating or eliminating factors contributing to falls while at the same time, maintaining or improving the resident’s mobility and quality of life.¹

PURPOSE:

1. Provide a safe environment for residents.
2. Minimize fall risk and overall number of falls.
3. Mitigate injuries from falls.

DEFINITIONS:

---Fall: A fall is any event whereby a resident “unintentionally comes to rest on the ground, floor, or other lower level, whether assisted or unassisted, resulting in injury or no injury, but not as result of an external force. A fall without injury is still a fall.”²

An assisted fall is still considered a fall.

PROCEDURE:

1. Screening for fall risk upon admission or significant change of condition:
   a. The RN completes the “Fall Risk” section of the Admission Nursing Assessment.
      i. Residents determined to be a high risk for falls will have a Care Plan (MR 318) completed by the RN (see section 2h, below).
      ii. Ancillary consults may be initiated for clarification of identified risk factors (e.g., drug regimen review from Pharmacy, or mobility assessment from the Rehabilitation Services Department).

2. After a fall:
   a. The RN assesses the resident for signs of injury and for changes in condition:

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¹ Tideiksaar, R. Falls in Older People. 3rd edition. Baltimore, MD: Health Professions Press.
i. If a serious injury is suspected, do not attempt to move the resident. Notify the physician immediately. If a physician is not immediately available, institute in-house emergency procedures (Nursing Policy and Procedures L 2.0)

ii. If a fracture is suspected, immobilize the affected area before moving the resident. If the area cannot be immobilized, stay with the resident and provide comfort until either the physician or EMS arrives.

b. After the initial assessment, if it is safe to do so, assist the resident to bed or chair. Do not lift the resident by the arms or legs. Do not attempt to transfer a resident off the floor alone, always use a minimum of 2 person assist. Whenever necessary, use a mechanical lifting device (e.g., EZ Lift, ceiling lift.).

i. Begin neurochecks if the resident hit their head or if the fall was unwitnessed.

ii. Check vital signs.

iii. Check for bruises, scrapes, lacerations, or any other injuries.

iv. If a fracture is suspected, monitor the pulses in the extremity distal to the suspected fracture to ensure that blood flow is not occluded.

c. Notify the attending physician:

i. When appropriate, the physician evaluates the resident for injury and documents accordingly in the medical record.

i-ii. The attending physician will evaluate the resident under the following circumstances:

- Loss of consciousness.
- Head injury.
- Lacerations.
- Deep bruising.
- Pain in the hip or in the groin.
- Pain or swelling, or if a bone has an unusual shape (e.g., shortening and/or unusual rotation of the body part).
- Difficulty or pain when standing or trying to walk.
- Limping, or other unsteadiness in gait (not present prior to the fall).
- Any other circumstances where the evaluating nurse feels the resident has sustained injuries requiring evaluation by the physician.

d. Notify the Supervisor/Nurse Manager

e. Notify the Medical Social Worker of the fall.

f. Notify the resident’s family or legal representative.
g. Documentation:

(1) Initiate a Post Fall Assessment Form (MR 524 – Appendix A)

(a) The Post-Fall Assessment form (MR 524) is to be completed subsequent to any resident fall.

- Place a short note in the Integrated Progress Notes indicating that a fall has occurred and that the Post Fall Assessment was initiated.
- A copy of the front page of the Post-Fall Assessment form should be attached to the Unusual Occurrence report.

(b) Complete each section of the Post-Fall Assessment form.

- For check boxes, there should be at least one box checked in each section unless otherwise indicated.
- Enter written information in the comments sections or narrative lines, as appropriate.

(c) On the second page of the Post-Fall Assessment form below the heavy line, there is a section for monitoring adverse effects from the fall.

- Place the Post-Fall Assessment form in the Medication Administration Record (MAR) for 72 hours post fall.
- Each shift will document on the Post-Fall Assessment form until the completion of the 72-hour period. Checking a box in the + column indicates that the associated assessment was observed.
  - Start the monitoring grid (below the solid line on the second page) on the shift immediately following the shift when the fall occurred.
  - All + boxes that are checked should have a corresponding note in the Integrated Progress Note section in the resident’s chart.
  - If the resident struck their head during the fall or the fall was unwitnessed then a neurological assessment form should be initiated.
  - Checking a box in the – column indicates that the associated assessment was not observed.
  - If there is another fall within the 72-hour observation period, then discontinue the Post-Fall Assessment form (draw a diagonal line through
the unfinished shifts), start a new Post-Fall Assessment form, and re-start a new 72-hour observation period.

(d) After the 72-hour period, place the completed Post-Fall Assessment form in the Assessment Section of the resident’s medical record.

- Write a note in the integrated progress notes that the Post Fall Assessment was completed.

(e) The Post-Fall Assessment acts as the short term care plan following a fall.

(2) Include the outcome of a fall in subsequent weekly/monthly summaries until injuries or consequences are resolved.

h. If the resident does not have a Fall Risk Care Plan prior to fall, then initiate a new care plan, otherwise review the current problem description of “At Risk for Falls” in the Care Plan. If new risk factors or interventions are identified, update the resident’s Care Plan. Use the “Common Fall Risk Factors and Interventions” matrix in Appendix B to determine the associated fall risks relevant to the resident:

(1) Any identified risk factors should be listed under the “Problem” column in the Care Plan (e.g., Falls related to: history of frequent falls, multiple medications, lower extremity weakness, etc.)

(2) The goal of an “At Risk for Falls” care plan is to minimize the risk for falls, minimize the risk for injuries from falling and to maximize the resident’s functional mobility.

(3) Ancillary staff may be consulted as necessary to clarify risks and interventions (e.g., a drug regimen review by Pharmacy or a mobility assessment by the Rehabilitation Services Department).

(4) Once the falls risk factors have been identified, the Nursing staff and/or Resident Care Team (RCT) will identify and implement interventions that can be used to address the resident’s risk factors.

(a) Use the “Common Fall Risk Factors and Interventions” matrix in Appendix B for intervention ideas.

(b) Interventions chosen for the resident will be entered under the “Intervention” column in the Care Plan.

i. Complete an Unusual Occurrence report. Refer to LHHPP 60-04 Unusual Occurrences for UO form F-821A “Confidential Report of Unusual Occurrence.”
j. A special meeting of the RCT may be required. The RCT will finalize Care Plan revisions in their review.

**ATTACHMENTS:**
- Appendix A: Post Fall Risk Assessment and Documentation Guidelines
- Appendix B: Common Fall Risk Factors and Interventions
- Post Fall Assessment Form MR 524

**REFERENCES:**
- LHHPP 60-04 Unusual Occurrences, including F-821A “Confidential Report of Unusual Occurrence”
- NPP C 3.0 Documentation of Resident Care
EMPLOYEE INFLUENZA VACCINATION(S) POLICY AND USE OF SURGICAL MASKS WHEN VACCINATION(S) IS DECLINED

POLICY:

All Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) staff will receive the influenza vaccine(s), unless medically contraindicated, during the influenza season as defined by the Centers for Disease Control for the northern hemisphere for the current year in order to protect the health and wellbeing of Laguna Honda residents who are particularly vulnerable to exposure.

PURPOSE:

The purpose of this policy is to:

1. Provide explicit standards for all Laguna Honda staff regarding required influenza vaccine(s) for the influenza season, to protect residents and staff from exposure to the influenza virus.

2. Ensure Laguna Honda managers, department heads, section leaders and staff is informed of required influenza policies and procedures. This communication will be conveyed by e-mail, intranet website postings, phone messages, all staff meetings, memoranda, messages from CEO, etc.

3. Ensure that policies and procedures are in place, and have been provided to management and staff for those individuals who decline the Influenza vaccine requirement.

4. Ensure that the declination process for those staff declining Influenza vaccine(s) is completed by a specific date.

5. Ensure that staff who decline the influenza vaccine are required to wear a surgical mask for the duration of the influenza season in the hospital building except staff break rooms, when working in a resident care area. Resident care area is defined as the new building including neighborhoods, clinic, radiology department, rehab gym, wellness center, art studio, library, Kanaley Center and any location in the building when you are within 6 feet of a resident. The exception to a resident care area in the new building is staff break rooms.

5.6. Staff working in isolation rooms must follow the standard of masking required for the specific resident involved.

6. Ensure that Employee Health Services, Infection Control Committee, and Hospital Administration designate December 15 as the date when the mask requirement will begin, subject to the status of the influenza season within the community.
7.8. Enforce the influenza vaccine(s) requirement of Laguna Honda staff in order to protect the health and safety of patients/residents, staff and visitors.

BACKGROUND:

1. Influenza is a serious respiratory disease that kills approximately 36,000 persons in the United States every year.

2. Hospitalized patients are particularly vulnerable to disease exposures.

3. Patient/resident safety is the underlying goal of all influenza policies.

4. Health care worker safety is inextricably linked to patient/resident safety.

5. The influenza virus may be shed for up to 48 hours before the health care worker feels sick or exhibits classic symptoms. Up to 30% of people with influenza have no symptoms, allowing inadvertent and unknowing transmission to patients and coworkers.

PROCEDURE:

1. When the recommended influenza vaccine(s) becomes available to Laguna Honda, employees will be able to obtain the influenza vaccine(s) from Employee Health Services. The influenza vaccine(s) will be available free of charge.

2. Employee Health Services will make every reasonable attempt to reach out to Laguna Honda employees and accommodate their work schedule.

3. The employee must present their identification (ID) badge, review the Vaccine Information Statements (VIS) issued and updated by the Centers for Disease Control, and indicate their consent to the influenza vaccine(s) on the VIS form prior to receiving the influenza vaccine(s). Pregnant staff are asked to consult their physician prior to being vaccinated. Mercury free vaccines are to be provided to all pregnant staff.

4. Employees who have not received the influenza vaccine(s) elsewhere, and decline influenza vaccine(s) offered at Laguna Honda, shall be required to wear a surgical mask for the duration of the influenza season when in resident care area in the hospital building except staff break rooms. (as defined above) and when employees can reasonably expect that s/he will be within 6 feet of the patient/resident regardless of location. Staff will isbe expected to manage their mask use to conform to health and safety standards to protect patients/residents and co-workers.
5. Vaccinated staff will be given a sticker on their ID Badge. A list of all staff who have been vaccinated will be available at the nursing office and the Employee health Services M-F 7:30 a.m. - 4:00 p.m.

6. Should a public health disaster be declared, in State of California and/or Federal Government, the above procedures outlined in this policy and procedure may be changed.

7. For those Laguna Honda staff incurring days off work due to influenza illness, accrued sick leave will be used pending adjudication, if indicated, of any claim of workplace acquired illness.

8. Laguna Honda staff will report suspected influenza-like illness to the appropriate unit managers and follow the Respiratory Viral Illness Screening For Staff And Return to Work Algorithm (refer to Appendix A).

9. Occupational Health Services and Infection Control Committee will revise policies as needed according to current evidence based recommendations.

ATTACHMENT:
Appendix A: Screening for Staff and Guidance for Return to Work Algorithm

REFERENCE:
None.

Revised: 13/01/29, 14/11/25, 17/01/10 (Year/Month/Day)
Original adoption: 09/12/15
APPENDIX A:

RESPIRATORY VIRAL ILLNESS (including Influenza) SCREENING FOR STAFF

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Stay At Home</th>
<th>Return to Work</th>
</tr>
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<tbody>
<tr>
<td><strong>FEVER</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Fever (T38C or 100.4F)</td>
<td>T &gt; 38C or 100.4F</td>
<td>• No fever for 24 hours¹</td>
</tr>
<tr>
<td><strong>RESPIRATORY SYMPTOMS WITHOUT FEVER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cough</td>
<td>Two or more symptoms ²</td>
<td>• 24 hours after onset of symptoms AND</td>
</tr>
<tr>
<td>• Sore throat</td>
<td></td>
<td>• No fever ¹ AND</td>
</tr>
<tr>
<td>• Nasal Congestion / Runny Nose</td>
<td></td>
<td>• Symptoms have significantly improved</td>
</tr>
<tr>
<td>• Myalgia (body aches)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza)</strong></td>
<td>T &gt; 38C or 100.4F and at least one symptom</td>
<td>• At least 5 days after onset of symptoms³ AND</td>
</tr>
<tr>
<td>• Fever (T38C or 100.4F)</td>
<td></td>
<td>• No fever for 24 hours¹ AND</td>
</tr>
<tr>
<td>• Cough</td>
<td></td>
<td>• Symptoms have significantly improved</td>
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<td>• Sore throat</td>
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<td>• Nasal Congestion / Runny Nose</td>
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<td></td>
</tr>
<tr>
<td>• Myalgia (body aches)</td>
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</tbody>
</table>

AND GUIDANCE FOR RETURN TO WORK

1. Assumes the individual has not taken fever-reducing medication (e.g. Tylenol, Motrin).

2. If you have received the seasonal influenza vaccine, you may work with minimal symptoms if you adhere to excellent hand hygiene and wear a mask when performing direct patient care activities.

3. For the purposes of counting the days, the onset of symptoms happens on Day 0. Day 1 begins the next calendar day. e.g. Symptoms begin on Sunday; Sunday is day zero; Monday is day one; and Friday is day five. You can return to work if well.

Questions about the process should be directed to the Laguna Honda Infection Control Department at ext. 4-2345.
MAINTAINING TEMPERATURE OF MEDICATION and NOURISHMENT REFRIGERATORS VIA TEMPTRAK & CLEANLINESS OF REFRIGERATORS

POLICY:

1. The types of refrigerators in the neighborhoods are: medication, nourishment, and employee’s refrigerators.

2. Temperature Ranges:
   - Medication refrigerator: between 36 and 46 degrees Fahrenheit.
   - Nourishment refrigerator: between 33 and 41 degrees Fahrenheit.
   - Galley freezer: between -10 and 0 degrees Fahrenheit.

3. Licensed Nurse is to check the temperature of nourishment refrigerators, medication refrigerators and galley freezers twice a day, on the AM and PM shifts by logging on to TempTrak.

4. If these equipment go out of range continuously over 2 hours, an additional online check via TempTrak must be done.

5. If the nourishment refrigerators and galley freezers out of range:
   a. Licensed nurse needs to check the refrigerator/freezer and close if opened or do other corrective action as needed.
   b. The licensed nurse will log into TempTrak database to document action taken.
   c. Licensed nurse shall check the refrigerator after an hour to ensure temperature correct. If still NOT within range, call Facilities and create a work order.

6. The Charge Nurse will be alerted through pager. This will require for a licensed nurse to log on to TempTrak, select the appropriate corrective actions to cancel the alert, and then perform the correction physically on the equipment.

4-6. Medication refrigerators are only used for medication requiring refrigeration. The medication refrigerators are located in the medication rooms and must be kept locked at all times.

5-7. If the temperature of a refrigerator containing medications is out of range, the licensed nurse is to contact the pharmacy for instructions on what to do with the refrigerated medications.

6-8. Nourishment refrigerators are only used for storage of resident's nourishments / supplements. The nourishment refrigerators are located in the Great Room and Galley in each neighborhood. Nourishment refrigerators in the Great Room must be kept locked at all times. The key is kept in the nursing station.

7-9. All food in refrigerators should be stored in covered containers. Food not in original container is to be clearly labeled and dated.
8.10. Licensed Nurses, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) must check the dates of refrigerated foods before serving and discard immediately if outdated.

9.11. Employees must store their food in the designated refrigerator in the staff lounge.

PURPOSE:

To store substances that require refrigeration in a hygienic refrigerator environment at the correct temperature.

BACKGROUND:

Temperature readings are displayed in the monitor located at the bottom of the refrigerator doors. Temperatures are also displayed online on real time on TempTrak.

PROCEDURE:

A. Equipment

Obtain from ward supply: clean basin, mild soap, clean cloths

B. Cleaning of the Refrigerator

1. Remove food containers and medications prior to cleaning the refrigerators. Using warm water and mild soap wash inside refrigerator with clean cloth.

2. Wipe dry with clean cloth.

3. Racks or shelves must be thoroughly washed and dried.

4. After cleaning and drying inside of refrigerator, return contents.

5. Wipe off the outside of refrigerator.

C. Maintenance of the Refrigerator

1. It is the responsibilities of the A.M. and P.M. shift Licensed Nurses to check for correct temperature.

2. It is the responsibility of the A.M. shift Licensed Nurses to check for any outdated food or medications in the medication and nourishment refrigerators. The A.M. Nursing Supervisors and Nurse Managers will monitor for ongoing compliance for timely removal of outdated foods.

3. The A.M. shift assigned C.N.A. or P.C.A. is responsible for cleaning the nourishment and employees refrigerators. Cleaning of these refrigerators is neighborhood based as scheduled by the Nurse Manager or Charge Nurse.

4. All nursing staff are responsible for discarding any unlabelled or expired foods found during their shift.
D. Food Storage

Food sent by Nutrition Services for nourishments are stored in the Great Room or Galley refrigerators. All containers must be labeled with expired dates. Outdated and unmarked foods are to be discarded immediately.

E. Reporting and/or Documentation

1. On the Emergency Checklist, the AM and the PM shifts will initial TempTrak to signify that they logged on to TempTrak.

2. Report any malfunctions or incorrect temperature settings to Facility Services, Licensed Nurse to complete an online work requisition for repair.

ATTACHMENTS:

Attachment 1: Emergency Equipment / Wireless Temperature Monitoring System Checklist

Attachment 2: TempTrak: Quick Reference Guide for Nurses

CROSS REFERENCE:

LHHPP 31-01 Wireless Temperature Monitoring System
Infection Control Manual: Section E Department Policies: Policy Number E8 Food Service

REFERENCE:


Reviewed: 01/13/2015

Approved: 01/13/2015
OXYGEN ADMINISTRATION

POLICY:

1. A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.

2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.

3. Residents requiring continuous oxygen at greater than 2 lpm shall be placed in a room that has wall oxygen.

4. Oxygen tank shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.

Oxygen is not to be given without physician approval for residents with COPD, or isolated blue limbs, or for residents where orders have been written specifically for "No Oxygen".

A licensed nurse may administer oxygen (with mask or bag ventilator) pending the physician's arrival in emergencies of cardiac arrest, diffuse cyanosis, seizures, witnessed or suspected aspiration, choking (after attempts to clear airway), chest pain, angina, suspicion of angina in residents with known coronary artery disease, acute respiratory distress, or massive acute bleeding.

The physician is to be contacted as soon as possible when oxygen is given to residents who do not have specific orders for oxygen.

PURPOSE:

To safely administer oxygen therapy to the hypoxic resident to increase the level of oxygen concentration in the tissues.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply. (The day shift is to order humidifiers from Central Supply to have available on the unit for the A.M. shift.)

2. Obtain from Central Supply, as needed:

"NO SMOKING" sign(s)
Small “E” tank oxygen cylinder with valve protection device attached and gauge wrench. (Each Unit-North will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)

Large “H” tank with valve protection device as needed for resident use.

Appropriate regulator

“Christmas tree” Compressed Air Connector adaptor if no humidification required

Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm-oxygen.

3. The licensed nurse is to verify the availability of emergency oxygen and supplies in the treatment room every morning, and record on the Emergency Equipment Checklist.

B. Safety measures for oxygen are to be followed.

1. There is to be "NO-SMOKING OXYGEN IN USE" in the area of oxygen use or storage.

2. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.

3. “OXYGEN IN USE” signs are to be clearly visible:
   a. on neck of oxygen or compressed air tanks in use or stored outside of resident’s room

4. No alcohol or tincture, oil, glycerin, Vaseline or petroleum product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure it is turned off and stored in bags.

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:
   a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
   b. Always look at the cylinder gauge to determine contents before administering any.
   c. Oxygen cylinders in storage shall be equipped with valve protection devices, and stored in oxygen cabinet.
   d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
   e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.
   c. When an oxygen tank is put into use, tear off the bottom one-third of the tag on the neck of the tank which reads “full.” The lower portion of the tag will then read “in use.” When the tank has 200 pounds pressure left in the tank, tear off the “in use” portion of the tag, which will now identify the tank as “empty.” Get a full tank from Central Supply if resident is to continue receiving oxygen. Oxygen concentrators are also an option.

C. Setting up and monitoring oxygen cylinders:
1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.
4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be pasted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and Christmas compressed air connector will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder.
9. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply.

D. Breaking down oxygen cylinders.
1. Remove regulators from cylinders.
2. Place valve covers on cylinders.
3. Return empty cylinders to Central Supply.

E. Preparation of the Resident and Visitors:
1. Explain the procedure and reasons for it to the resident.
   a. Show resident the catheter or mask to be used.
   b. Reassure resident that you will be checking him/her.
   c. Elevate the head of the bed.
   d. Check that the call light is accessible. Give instruction on how to operate the call light, if needed. Reassure the resident that you want him/her to turn on the call light to inform you of any difficulties.
   e. If the resident is apprehensive, and if staffing permits, assign someone to stay with him/her until he adjusts.
2. Explain the "NO SMOKING" policy to the resident and visitors. Residents are to smoke only in designated areas. Remove matches and cigarettes from unsafe smokers.

F. Preparation of Equipment:
1. Place "NO SMOKING" signs according to policy.
2. Wash hands.
3. Connect tubing to the flowmeter or humidifier and the administering device.
4. Assess equipment for proper functioning. Open oxygen flowmeter. There should be bubbles visible in the water of the humidifier, if used.

G. Administration:
1. Apply and adjust nasal cannula, mask or catheter to resident. Check placement frequently. If needed, use 4 x 4 gauze to cushion tubing that presses against the face or ears. Keep skin clean and dry. Observe these skin areas for skin breaks when oxygen is prolonged.

2. Turn on the oxygen and adjust flow rates as prescribed.

3. Increase frequency of oral hygiene as needed by resident's condition.

4. Nasal oxygen administered at 4 liters or less/minute does not need to be routinely humidified.

5. When humidifiers are used with oxygen, use pre-filled humidifier.

6. All used disposable oxygen administration devices shall be replaced and tubing will be labelled with the date and initials of nursing staff every 24 hours and as needed. Daily, the AM shift licensed nurse will change all disposable oxygen devices, including but not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula or catheter, mask or tracheostomy mask, and replace with new devices. Documentation of the replacement shall be noted in the resident's treatment sheet.

7. Check oxygen flow rate at frequent intervals.

8. Observe the resident frequently for signs of insufficient oxygen which may include:
   a. BP - increase above baseline or narrowed pulse pressure,
   b. Pulse - tachycardia,
   c. Respiration changes in rate, rhythm, depth, absence or presence of dyspnea,
   d. Decreased mental alertness - confusion, restlessness,
   e. Changes in skin and fingernail color, perspiration.

9. For Infection Control purposes, the opened nasal cannula, when not in use, will be stored in a clean bag.

H. Methods of Administration

Refer to Respiratory Services Departmental Policies and Procedures in the Cross Reference Section or The Lippincott Manual of Nursing Practice listed in the Reference Section of this NPP for Administering Oxygen by Nasal Cannula, Simple Face Mask With/Without Aerosol, Venturi Mask (High air flow oxygen entrainment [HAFOE] system, Partial Rebreathing or Nonrebreathing Mask, Continuous Positive Airway Pressure Mask, or by Manual Resuscitation Bag.

I. Documentation for Oxygen:

1. Order Sheet: When noting oxygen orders on the physician's order sheet, code with the letter "T" in the Code column and transcribe to treatment sheet.

2. Tubing Label: All disposable used oxygen administration devices shall be labelled with the date and initials every 24 hours and as needed.

3. Treatment Sheet-Administration Record (TAR)
Oxygen Administration

a. Front side of treatment sheet administration record

   i. For continuous use of oxygen each shift, the licensed nurse signs her initials for the time and date opposite the order, then writes initials, signature and title in the signature section.

   ii. For PRN use of oxygen, sign initials each time the oxygen is given.

   iii. When treatment is given by the respiratory therapist, the licensed nurse circles the correct time box and writes "RT" and her initials. Respiratory therapist does his own documentation.

   iv. The replacement of all disposable used oxygen administration devices shall be noted on the resident's TAR to serve as a reminder of the practice for all devices to be replaced by AM shift nursing staff.

   iv. The AM shift licensed nurse will replace all disposable oxygen administration devices every 24 hours. The replacement shall be noted in the front side of the resident treatment sheet.

b. Reverse side of treatment sheet – Progress Notes

   For PRN use of oxygen, each time oxygen is given, include a comment about how the oxygen was tolerated.

3. Graphic Sheet Electronic Charting Health Record

   Vital signs are recorded in the Electronic Health Record (LCREHR) respiration and pulse PRN, based on the judgment of the nurse.

4. Integrated Progress Notes – Monthly/weekly summary or more frequent PRN charting based upon the resident's condition and the judgment of the nurse.

   a. Resident's response to treatment including adverse reactions and tolerance to the procedure, which may include the following items, as applicable.

      i. Date, time and person performing the procedure
      ii. Oxygen liter flow rate
      iii. Method, frequency and duration of administration
      iv. Specific assessments which may include vital signs, skin color, and level of consciousness.

   b. Resident teaching done and the resident's level of understanding and compliance.

5. Include oxygen administration and respiratory status on the Resident Care Plan.
Oxygen Administration

ATTACHMENTS/APPENDICES:

I 5.0 Attachment 1: Oxygen Therapy Devices

REFERENCES:

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

CROSS REFERENCES:

Respiratory Services Policies & Procedures:
A 2. Safety Regulations for Oxygen Therapy
A 6. Oxygen Administration: Nasal Cannula
A 7. Oxygen Administration: Simple- Oxygen Mask
A 8. Oxygen Administration: Non-Rebreather Mask
A 9. Oxygen Administration: Venturi Mask


Reviewed: __________
OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS

POLICYIES:

1. The charge nurse or team leader is responsible to have a continuous supply of prescribed medications available 24 hours a day, seven days a week through Department of Pharmacy Services or automated medication dispensing cabinets.

2. The medication room, medication cart, treatment cart, and biological refrigerator are to be locked when not in use or attended.

3. Complete an Unusual Occurrence if there is an error in the medication dispensed, or labeling error. Return the drug to Pharmacy immediately and obtain a replacement. If Pharmacy is closed, give the medication to a nursing supervisor.

4. Licensed nurse adheres to relevant policies and procedures outlined by the Department of Pharmacy Services.

PURPOSE:

Correct medications will be available and stored properly.

PROCEDURES:

A. Pharmacy Accessibility (Refer to Pharmacy Administration P&PPolicy 01.01.01).

B. Obtaining medication from Pharmacy

1. New medication orders will be transmitted to pharmacy as an electronic prescription via the electronic health record or faxed if written on a physician order sheet. The licensed nurse or licensed psychiatric technician may obtain medications from Pharmacy either by faxing the order sheet to Pharmacy or bringing the order sheet to pharmacy in person. Medications will be available via automated dispensing cabinet or patient specific supply delivered by pharmacy. Medications needed prior to the next pharmacy delivery may be picked up at the pharmacy window by a licensed nurse or licensed psychiatric technician.

2. Maintenance Medications:
   a. Pharmacy will deliver medication cassettes to the nursing neighborhood. The Cassette will contain the medication supply for each resident.
   b. For new ordered medication, pharmacy will dispense the amount of medication up to the next cassette exchange.

3. Short-term Medications:

   Pharmacy will dispense only the amount of medication that was specified in the order.

4. PRN or “As Needed” Medications (Refer to Pharmacy Administration P&PPolicy 09.01.00).

5. Medication Refills
Obtaining, Handling, and Storage of Medications

If refill is needed before routine date of replacement put empty drug container or tubes in pharmacy pick up tray. Request the refill via pharmacy software web-connect. If systems are down, write resident name and medication on pharmacy requisition and fax request for refill to pharmacy.

6. Stock Items (Refer to Pharmacy Administration P&P Policy 09.01.00).

7. Controlled Substance Medications Pharmacy Administration P&P Policies 09.01.00 and 02.02.00).

C. Labeling Medications

1. The pharmacist inspects the condition and legibility of labels. All prescription drugs that do not have a clearly legible label are to be returned to Pharmacy for replacement.

2. Label Changes:
   a. If label becomes soiled, illegible, or if change is made in dosage or frequency of an existing medication, the drug container is to be placed in a relabel zip lock bag and placed in the pharmacy pick up tray.
   b. In the event that the correct dose for the resident involves more than one strength of medication, the medication container will show a green "Note dosage strength" sticker alert. This is affixed by pharmacy to heighten nurse ability to dose accurately.

D. Storage of Medications

1. Condition of Container and Contents:
   a. Medications are to be kept in the containers received from Pharmacy. If containers become cracked, soiled, or do not have secure closures, return to Pharmacy for replacement.
   b. If drug contents become outdated, contaminated or show deterioration, return to Pharmacy for replacement.

2. Orderliness of Medications
   a. Medication Cart:
      Medication cart stores the resident's supply of internal medication including injectables, ophthalmic preparations, otic preparations and inhalation preparations (nebulizer/aerosol).

   b. Treatment cart:
      i. Ointments and creams are labeled with resident's name and are legible. All medication tubes and bottles are to have covers.
      ii. Irrigating solutions are checked for expiration date labeling. Normal saline and sterile water are ordered from Central Supply. Other irrigation solutions are ordered from Pharmacy and are labeled with expiration dates. Unlabeled or unopened expired solutions are to be returned.
      iii. When bottles of irrigation solution are first opened, write the date, time and nurse's initials on the label. Refer to Pharmacy Policy 02.01.06 Appendix 1 for expiration policies and practice.
iv. Irrigation solutions are not to be used after expiration dates determined by Pharmacy and the time the container is first opened.

c. Medication Room

Licensed nurse checks expiration dates of medications before administering medication and on a weekly or monthly basis. All unlabeled and expired medications are to be discarded in the medication waste bin.

The following items are stored in locked medication room, locked cabinets, carts and/or the automatic dispensing cabinet(s). Internal, external, and injectable items must be stored separately.

i. Approved ward stock supplies or medications.
ii. Emergency drug box, Emergency I.V. bag, I.V. solutions and tubing.
iii. Test reagents, Chemstrips, or hemoccult tests.

3. Biological refrigerator - is used only for drugs needing refrigeration.

a. Refrigerator temperature is checked twice daily by licensed nurse. The temperature is to be between 2 degrees centigrade (36 degrees Fahrenheit) and 8 degrees centigrade (46 degrees Fahrenheit) monitored continuously via wireless refrigerator monitoring system. The temperature log is checked twice daily by nursing staff (Refer to see LHHHWPP 31-01).

b. Store oral medications together in one area, refrigerated injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.

c. No food or specimens are to be placed in the biological refrigerator.

4. Emergency Drug Box / Crash Cart

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

a. DAY Shift licensed nurse checks lock of Crash Cart daily.
b. “Red lock” of the Emergency Drug Box is checked by licensed nurse every shift.

* For Wellness Center ONLY - Emergency Equipment such as AED & Crash Cart must be checked daily by Day Shift Licensed Nurses assigned to Pavilion – Mezzanine SNF.

E. Handling Medications

1. Oral Liquid Syringe Dispenser is used to accurately measure liquid medications such as Dilantin suspension. Shake the suspension medication well and be sure the syringe plunger is fully depressed before inverting the bottle to fill the syringe. Use the inside edge of the black measurement ring to read volume. The syringe may be attached to an enteric tube or put into the mouth between the teeth and cheek to administer medication. Discard dispenser after each individual dose.

2. Holding Medications

Hold Meds = Discontinuation (D/C) (Refer to LHHHWPP 25-05).
3. Hazardous Medications (formerly known as antineoplastic / cytotoxic medications)

Special precaution needs to be applied when preparing and handling hazardous medication administration. (Refer to LHH/HWP PP 25-05).

4. Controlled Substance Medications (Refer to Pharmacy Administration P&P Policy 02.02.00).

5. Multidose Vials:
   a. Multiple dose vials of injectables shall be visually inspected prior to use and discarded if any of the following occur:
      i. There is a change in appearance of the solution.
      ii. There is damage or loss of integrity of the closure.
      iii. The drug has been improperly stored.
      iv. The vial is known or suspected to be contaminated
   b. Expiration Dating (Refer to Pharmacy Policy 02.01.06 Appendix 1).
   c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.
   d. Insulin vials shall be:
      i. Dated upon initial entry.
      ii. Open vials may be kept in individual resident cassettes or in the refrigerator.
      iii. Open, in-use vials shall be discarded after 28 days.
      iv. Intact vials are to be kept in the refrigerator until the manufacturer’s expiration date on the vial.
   e. Injectables that contain preservatives shall be:
      i. Dated upon initial entry.
      ii. Refrigerated for stability, if recommended by the manufacturer.
      iii. Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).

6. Resident Transfers:
   a. When a resident is relocated within LHH, the nurse will send the resident's medication to the receiving neighborhood.
   b. When a resident is transferred to or from an acute unit, the resident’s medicines are not sent with the resident if the pharmacy is open. New orders must be written and sent to pharmacy for filling. If the pharmacy is closed at the time of transfer to or from the acute care household, the nurse will send the medications to the receiving unit. The medications will be sent to the pharmacy for relabeling when the pharmacy opens.

7. Discontinued Medications:
   a. Immediately after the medication is discontinued, send or fax the order to Pharmacy, print "DC" on the prescription label and place the medication in the pharmacy pick-up box. This also applies to the medications of residents who expire.
   b. Resident Discharges:
Obtaining, Handling, and Storage of Medications

LHH Nursing Policies and Procedures

i. When a resident is discharged to any acute setting all medications must be returned to pharmacy.
ii. When a resident is discharged to community, the licensed nurse is to inform the Pharmacy when discharge orders are written. All in-house medications must be returned to pharmacy after resident discharged.

F. Monthly Pharmacy Ward Survey

1. The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered to the resident to ascertain that medications are given accurately and with acceptable infection control measures employed.
2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.

G. Out-On-Pass Medications

1. For planned trips away from the hospital, the attending physician is to write an order for each out-on-pass medication, including the number of days needed. The order shall include the name of the medication, strength, and directions for use.
   a. The nurse will have the order filled at the hospital Pharmacy.
   b. The pharmacist will dispense the medications in properly labeled child-proof containers.
   c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.
   d. A security prescription form is necessary for all Outpatient out on pass controlled substance prescriptions. Alternatively, except CII controlled substance prescriptions, physician may fax prescriptions for CIII-V to the pharmacy on a regular physician order form.
2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.
   a. Controlled substances may not be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.
   b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.
   c. The physician will counsel the resident on proper use of his/her medications.
3. The nurse will note in the Medication Administration Record that the resident is out on pass with a supply of medication.

H. 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. 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 writes the order to use them. 

d. 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 give the medication unless it has been relabeled by LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LH physician, and shall not be kept at bedside unless approved for self administration.

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.

CROSS REFERENCES:

LHHPP File: 25-01 High Risk - High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 31-01 Wireless Refrigerator and Freezer Temperature monitoring System
LHH Pharmacy Administration P&P 01.01.01 Accessibility to Medications
LHH Pharmacy Administration P&P 01.02.02 Stop Orders
LHH Pharmacy Administration P&P 01.08.00 Extern Students
LHH Pharmacy Administration P&P 02.02.00 Controlled Substance
LHH Pharmacy Administration P&P 02.01.06
Pharmacy Administration P&P 09.01.00 Automated Medication Dispensing Cabinets

Emergency Equipment/Refrigeration Monitoring Sheet
Emergency Equipment Monitoring Sheet for Wellness Center Only

Adopted from NPP J 1.0 12/2006

New: 4/2010

Revised: 03/17/2011; 07/14/2015, 01/10/2017

Reviewed: 07/14/201503/24/2011

Approved: 07/14/201503/24/2011
MANAGEMENT OF RESIDENTS ON HEMODIALYSIS

POLICY:

1. A physician’s order by a LHH physician or a nephrologist is required for hemodialysis and related lab work, diet orders, and medications.

2. All residents on hemodialysis are weighed daily at the same time each day, on the same scale with the same amount of clothing.

3. Coordination of nursing care for the resident undergoing hemodialysis is the joint responsibility of the LHH licensed nurse (LN) and the hemodialysis nurse.

4. Nursing interventions for pre and post hemodialysis care are care planned. The dialysis center phone numbers for routine and emergency consultation are listed in the care plan.

5. The licensed nurse will communicate to the dialysis nurse any clinically relevant change in the resident’s condition via securely fax dialysis communication form.

6. Dialysis catheters are NEVER used for blood draws or IV hydration, unless ordered by MD during life threatening situations.

The licensed nurse will monitor the AV shunt and fistula for audible bruit and palpable thrill at least daily and report absence of bruit and/or thrill to the LHH physician.

7. Dialysis schedule may be adjusted based on clinic visits or planned surgical procedures. Consult with physician and team.

PURPOSE:

To coordinate care of residents receiving hemodialysis treatment at an outside agency location through collaboration with the dialysis agency, its nephrologists, the Laguna Honda Hospital ward physician and nursing staff.

PROCEDURE:

A. Care Before Dialysis

1. LHH staff prepare resident for transport to dialysis treatment.
   a. Notify physician and dialysis nurse prior to transporting if resident has symptoms of acute illness.
Manageman of Residents on Hemodialysis

2. Consult with the pharmacist and/or physician regarding timing of anti-diabetic medications and water soluble medications.

3. Report any change in the resident’s physical and emotional status or any new physician’s orders to the dialysis nurse or technician. Send the primary physician’s phone number and pager.

4. If the resident is unable to eat during dialysis, arrange for a tray to be served later. Send a bag lunch meal with the resident when indicated.

4. Securely fax the Dialysis Communication Form to the dialysis center for any pertinent information that the dialysis center needs regarding current condition of the resident.

B. Care Immediately After Dialysis

1. The licensed nurse LN reviews the Dialysis Communication Form from dialysis center for any changes in condition of the resident post-dialysis.

2. The LN documents in the Integrated Progress Note any clinically relevant communication that is sent/faxed between LHH and the dialysis center.

3. The LN notifies the LHH physician immediately of changes in dialysis venous access device patency and laboratory values outside acceptable ranges for the resident. Consultation with the dialysis clinic nurse or physician is done as needed.

3.4. The LN receives a resident status report from the dialysis nurse to include:
   a. dry weight from dialysis
   b. fluid status/balance
   c. vital signs/tolerance of procedure
   d. lab tests and results
   e. medications given or with held
   f. blood transfusion if given
   g. unusual events
   h. type of temporary hemodialysis access

4.5. The LN assesses observes for any bleeding at the access site upon return from dialysis.

5.6. The LN assesses observes shunt-fistula for thrill and bruit. If pulsation-thrill or bruit is absent, notifies the physician immediately.

7. Perform vital signs upon return from dialysis and prn unless ordered otherwise. Report any significant changes to the physician.

8. Fluid Monitoring (refer to NPP G 3.0 Intake & Output).
C. Vascular Access Precautions

1. Constrictive clothing or jewelry cannot be worn on the extremity with dialysis access.

2. Venipuncture for laboratory tests, I.V. fluids, or taking blood pressure may not be performed on the extremity with dialysis access.
   a. A sign should be posted at the head of the bed to alert health team members not to use extremity with shunt or fistula.

D. Tunneled Dialysis Catheter Care

1. The dialysis nurse will perform the dressing change of the shunt or dialysis catheter during each treatment dressing changes at each dialysis center.

2. Neighborhood RN may perform dressing reinforcement if dressing is soiled or loosened.

   Strict sterile technique must be practiced.

E. Care Between Dialysis Treatments

Vital signs and weight are taken on the neighborhood prior to sending resident to dialysis. are taken daily and prn for assessment of the resident’s physical condition.

Vital signs are taken upon resident return from dialysis.

Weigh resident at the same time of day, on the same scale with the same amount of clothing.

Fluid Monitoring (refer to NPP G 3.0 Intake & Output).

1. If resident’s weight remains stable, weigh weekly and record.
2. If weights are not stable or if resident has shortness of breath or increasing edema, weigh and record daily. Weigh resident at the same time of each day, on the same scale with the same amount of clothing.

Fluid Monitoring (refer to NPP G 3.0 Intake & Output)

a. Resident is on fluid restriction,
   b. Physician’s order,
   c. Resident’s condition is unstable.

2. Oral hygiene (refer to Oral Hygiene P&P NPP D3 1.0 Oral Hygiene)
   a. Teach resident to use a soft toothbrush to gently brush teeth and gums. Use appropriate mouthwash as needed to reduce a pleasant lasting mouthwash or dilute vinegar mouthwash may improve the uremic taste in the mouth.
   b. Sour candies or lemons may improve the taste in the mouth and decrease thirst.

3. Skin care
   a. Keep the skin clean while relieving dryness and itching. Apply lotion while the skin is still moist after bathing.
   b. Keep nails trimmed to prevent skin excoriation from scratching.
   c. Guard against leg and foot trauma.
F. Resident Education

G. Emphasize resident's crucial role in protecting vascular access.

1. Explain precautions for the extremity with the vascular access.

2. Teach resident to assess venous patency, if is able to do so, report any changes or problems to vascular access.

3. Teach importance of following fluid intake limitations and appropriate diet.

I. F. Documentation

1. Resident Care Plan – see appendix "Hemodialysis Care Plan"

2. Treatment Assessment Record (TAR)
   a. Type of Access
   b. Assess Monitor Document presence or absence of AV shunt/fistula for audible bruit and palpable thrill.
   c. Condition of dialysis access site.
   d. Vital signs and weight
   e. No blood draw or b/p on (site)

3. LCR Weight Graphic Sheet: Height and Weight on each page

4. Interdisciplinary Progress Notes
   a. Resident response to dialysis treatments in weekly/monthly summary.
   b. Assessment of ability to comprehend and follow precautions needed for venous access, dietary and fluid requirements.
   c. Documentation health education or teachings given to resident.

5. Neighborhood Census Report: Outpatient hemodialysis is considered a clinic visit and therefore, is to be documented on the unit census report.

6. Resident Dialysis Binder:
   Dialysis Communication Form: Communication via secured fax To coordinate between dialysis nurse and unit nurse, place resident's changes or information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)

REFERENCES:


CROSS REFERENCES:

Nursing P&P D3 1.0 Oral Hygiene
Nursing P&P G 3.0 Intake and Output
Management of Residents on Hemodialysis

Nursing P&P Nursing Policies and Procedures J 7.0 Central Venous Access Device (CVAD) Management

APPENDICES:

Attachment 1: Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis
Attachment 2: Hemodialysis Communication Form Dialysis Communication Form
Attachment 3: Resident Care Plan Hemodialysis
Attachment 4: Dialysis TAR Template

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