List of Laguna Honda Hospital and Rehabilitation Center (LHH) Hospital-wide/Department Policies and Procedures Submitted to the Joint Conference Committee (JCC) for Approval on May 19, 2020

Hospital-wide Policies and Procedures

New Policies (page 3)

| <u>Policies</u> | Comments |
|------------------------------|---|
| 27-03 Natural Dye Swallowing | Created to describe procedures for natural dye swallowing |
| Assessment for Patients with | assessments to facilitate detection of aspiration in patients who |
| Tracheostomy | have a tracheostomy. |

Revised Policies (page 7)

| <u>Policies</u> | Comments |
|---------------------------------|--|
| 75-05 Illicit or Diverted Drugs | Revised to include new policy statement to state that SF |
| and/or Paraphernalia | Department of Public Health promotes Harm Reduction |
| Possession/Use by Residents or | methods and treatment goals; replaced "prohibited" with |
| Visitors (re-titled) | "diverted"; added definitions for diverted drug, MAT |
| | (Medication Assisted Treatment), and Harm Reduction; and |
| | added Appendix 1 for Process Map for Change in Condition |
| | Requiring Urine Toxicology Screen. |

Department: Environmental Services

Revised Policies (page 17)

| <u>Policies</u> | <u>Comments</u> |
|---|--|
| X Equipment, Supplies and | Revised to reflect current procedures for Environmental Services |
| Chemicals | equipment, supplies, and cleaning chemicals. |
| XII Transmission-Based Precautions Cleaning (re-titled) | Revised to reflect current procedures. |

Department: Medical Staff

Revised Policies (page 23)

| <u>Policies</u> | Comments |
|-----------------------------|---|
| D08 Psychiatric Emergencies | Revised to clarify that if a resident is transferred to Psychiatric |
| | Emergency Services, both the LHH Psychiatry provider and |
| | attending physician must agree to the resident's return to LHH |
| | based on the evaluation for behavioral risks. |

Department: Nursing Services

Revised Policies (page 29)

| <u>Policies</u> | Comments |
|---|--|
| C 4.0 Notification and Documentation of Change in | Revised to incorporate the urine toxicology screening algorithm and included in Appendix. |
| Resident Condition (re-titled) | |
| J 1.1 Obtaining, Handling, and Storage of Medications | New policy: Unless otherwise stated in the policy, the licensed nurse does not need to date products with the open date. Revised to indicate "Pharmacy will deliver resident specific supply of maintenance medications to the neighborhood with scheduled oral medications" Licensed nurse inspects condition of labels. Irrigation solutions are not used 24 hours after opening Removed holding medications Pharmacy assigns expiration date for medications |

Department: Pharmacy Services

Revised Policies (page 41)

| <u>Policies</u> | Comments |
|-------------------------------|---|
| 02.01.06 Expiration Dating of | Revised to add that pharmaceutical products that expire prior |
| Pharmaceuticals | to manufacturer's labeled expiration date due to opening or |
| | change in storage conditions shall be assigned and labeled with |
| | an expiration date based upon the manufacturer prescribing |
| | information; and revised Attachment 1 for list of |
| | medications/devices with special expiration date requirements. |

New Hospital-wide Policies and Procedures

NATURAL DYE SWALLOWING ASSESSMENT FOR PATIENTS WITH TRACHEOSTOMY

POLICY:

At Laguna Honda Hospital and Rehabilitation Center (LHH), natural dye testing is appropriate as one aspect of a comprehensive swallowing evaluation when the patient has a tracheostomy, is alert, awake, and able to tolerate the procedure. This is to augment a traditional bedside swallow evaluation and does not replace modified barium swallow study (MBSS) or fiber-optic endoscopic evaluation (FEES) for a differential diagnosis of dysphagia.

PURPOSE:

Natural dye swallow assessments facilitate detection of aspiration in patients who have a tracheostomy. NOTE: Natural dye testing is one component of a comprehensive swallowing evaluation but does not definitively rule-out aspiration.

PROCEDURE:

- 1. The physician shall order a swallow evaluation.
- 2. The speech language pathologist (SLP) shall conduct a thorough chart review.
- 3. If appropriate and with a physician's order, the patient shall be evaluated for a Passy-Muir Speaking Valve prior to the swallow evaluation (per LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir).
- 4. If the tracheostomy has an inflated cuff, a physician's order to deflate the cuff is obtained. If the patient cannot tolerate cuff deflation, the procedure is deferred or modified as clinically indicated.
- 5. The SLP shall coordinate the evaluation schedule with the Respiratory Care Practitioner (RCP).
- 6. The speech pathologist shall conduct an oral motor and laryngeal function examination.
- 7. Colored food/liquid (no red so as not to be mistaken for blood if suctioned) is selected for PO trials: grape juice if available, orange juice, grape/orange juice with thickener, chocolate pudding, banana slices coated with chocolate pudding, graham crackers coated with chocolate pudding.
- 8. The RCP shall suction the trachea prior to introduction of PO trials, clearing any secretions.

- 9. If appropriate, the assessment is conducted with a Passy-Muir Speaking Valve (PMSV) for improved subglottic pressure.
- 10. The SLP shall give the patient 3 tsp trials of water to determine presence of a swallow prior to continuing with the evaluation.
- 11. The SLP shall select the appropriate PO textures to be tested. One-to-two consistencies are tested daily per clinical judgement of the SLP.
- 12. The swallow assessment shall include the procedure defined in Rehabilitation Services Policies and Procedures 90-05: Establishment of Therapy Programs and Documentation: Dysphagia.
- 13. The trachea is suctioned by the RCP immediately after PO trials, examining tracheal secretions for evidence of colored food/liquid.
- 14. Nursing shall be notified to monitor for delayed natural dye in the tracheal secretions for the next 24 hours. If, as determined by the SLP, suctioning should be scheduled at specific intervals, the SLP shall request an order for suctioning, including frequency and duration. The SLP shall post a sign re: times of suctioning.
- 15. Findings, including recording suctioning of colored secretions, are documented in the FHR.
- 16. SLP documents results and recommendations on the dysphagia evaluation in the EHR, including recommendation for MBSS if indicated.
- 17. The physician is notified of results and recommendations.

ATTACHMENT:

None.

REFERENCE:

Fornatoaro-Clerici, Lisa and Roop, Thomas A.: Clinical Management of Adults Requiring Tracheostomy Tubes and Ventilators, A Reference Guide for Healthcare Practitioners Northern Speech Services, 1997.

Logemann, J.A.: Evaluation and Treatment of Swallowing Disorders. Austin Texas: Proed, Inc., 1998.

LHHPP 26-02: Management of Dysphagia and Aspiration Risk

LHHPP 27-01: Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir

LHHPP 27-05: Tracheostomy Management

Nursing I3-0: Tracheostomy Care

Rehabilitation Services 90-05: Establishment of Therapy Programs and Documentation:

Dysphagia

Original adoption: 20/05/12 (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

ILLICIT OR PROHIBITED DIVERTED DRUGS AND OR PARAPHERNALIA POSSESSION/USE BY RESIDENTS OR VISITORS

POLICY:

- As in the greater community, the use, possession, solicitation and/or distribution of illicit or prohibited diverted drugs and/or paraphernalia at Laguna Honda Hospital and Rehabilitation Center (LHH) is prohibited.
- 2. Staff shall take steps to prevent illicit or <u>prohibited_diverted_drugs_and/or</u> paraphernalia use or access, and shall promote and support resident efforts to minimize the health consequences of illicit or <u>divertedprohibited</u> drug <u>and/or</u> paraphernalia use.

The San Francisco Department of Public Health promotes Harm Reduction methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals, their family and community. Harm reduction methods and treatment goals are free of judgement or blame and directly involve the client in setting their own goals.

3.

PURPOSE:

- 1. ——To ensure LHH's capability to deliver effective health care to its residents by:
 - a. Minimizing the presence and use of illicit or diverted prohibited drugs at LHH;
 - b. Eliminating the presence of illicit or <u>diverted prohibited</u> <u>drugs and /or drug paraphernalia</u>;
 - c. Minimizing disease progression related to illicit or diverted prohibited drug use;
 - d. Maximizing therapeutic impact and safety of prescribed medication;
 - e. Maximizing the safety of the resident and other residents, staff, volunteers, and visitors; and
 - Complying with State and City laws and regulations.
 - f.g. Including strategies that reduce harm for those clients who are unable or unwilling to modify their unsafe behavior.

DEFINITIONS

• Illicit or illegal drug: A drug or substance that cannot be obtained legally or by prescription, or any substance prohibited by code or statute.

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- 2. Prohibited Diverted drug: Any drug that is intentionally and without proper authorization, used or taken possession of that is not prescribed for the resident. Examples of drug diversion include, but are not limited to, the following:
 - Medication theft, from other patients or organizations.
 - Using or taking possession of a medication without a valid order or prescription
 - Forging or inappropriately modifying a prescription.
- 1. A medication that has not been currently prescribed or authorized for the possessor.
- 3. Paraphernalia: Medical apparatus or over-the-counter items that are commonly used in illicit drug activity such as syringes, needles, drug pipes, hemostats, and so forth.
- 2.4. 4. STARS: LHH Substance Treatment and Recovery Services STARS: Substance Treatment and Recovery Services offered at Laguna Honda Hospital.
- 5. MAT: Medication Assisted Treatment for the use of substance abuse (specifically opioids).
- 6. Harm Reduction: SFDPH philosophy promoting methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community by reducing unsafe practices rather than abstaining from dangerous behavior.

3. PROCEDURE:

- 1. Illicit or Prohibited Diverted Drug Possession/Use by Residents
 - a. On admission to LHH, the Admissions and Eligibility Department representative shall inform the resident of this Illicit or <u>Prohibited Diverted Drug and/or Paraphernalia Possession/Use</u> policy and shall request that the resident acknowledge notification. The resident, or the resident's legal representative, affirms by his/her signature on the House Rules and Responsibilities that s/he understands and agrees to abide by the policy and procedure.
 - b. If the resident has a substance use disorder or a history of substance use, the admitting or attending physician shall recommend to the resident that s/he receives an assessment by a STARS clinician in addition to medical management. The referral for STARS can be made through LHH Psychiatry e-referral. STARS providers shall offer specialized services including group therapy, individual counseling, and recommendations about Medication Assisted Treatment (MAT) for substance use. For details on STARS service, see MSPP D08-07 LHH Substance Treatment and Recovery Services.
 - c. The Resident Care Team (RCT) shall identify the team member who shall address safety issues around substance use, once identified, with the resident whose behaviors related to substance use are negatively impacting their own care and/or affecting others. This is to ensure safety for all. Intervention options shall be reflected in the resident's care plan, which may

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include (but are not limited to) MAT, participation in STARS treatment, peer counseling, 12 Step groups, other psychosocial treatment and interventions, and San Francisco Sheriff's Department (SFSD) assistance in case of safety crisis.

- i. The attending physician shall offer MATSTARS, as indicated.
- ii. STARS and/or other LHH Psychiatry providers shall offer behavioral intervention recommendations. For details on LHH Psychiatry service on behavioral management, see MSPP D08-10 Behavioral Management Services by LHH Psychiatry.
- iii. RCT team members shall orient the resident to LHH safety rules, and address issues related to substance use through the care planning process. Clinical interventions may include limiting access to medications and/or illicit or process. Clinical interventions may include limiting access to medications and/or illicit or prohibited drugs (passes, access, visitors, etc.).
- iv. When any LHH staff member has reasonable grounds to conclude a resident is using illicit or prohibited_diverted drugs in violation of LHH policy, s/he shall inform the resident's attending physician or assigned physician coverage and the RCT.
 - If the physician determines reasonable grounds exist, urine or blood toxicologycomprehensive drug screens shall be obtained, consistent with the signed Conditions of Admission.
 - If the resident refuses testing and is competent to refuse, (a) the refusal shall be considered the same as a positive result, and (b) further hospitalization may be conditional upon the resident's desire to comply with LHH policy.

PROCEDURE:

- 1. Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX)
 - a. Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX) would include an altered level of conscious ness, abnormal vital signs (RR<12), somnolence. Observable signs of intoxication as well as sign of overdose (not breathing, unresponsive, lips and fingers turning blue/grey, gurgling sounds, rigid limbs), for which a code must be called.</p>
 - I. Provider to evaluate resident exhibiting a change of condition based upon signs and symptoms communicated by staff.
 - II. A urine toxicology (UTOX) screen shall be requested from the ED by provider any time a resident is determined to require and ED visit.
 - III. The Charge Nurse shall complete Unusual Occurrence and submit to Quality

 Management (QM) any time a resident is determined to require and ED visit.

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- IV. If resident does NOT require ED visit the provider shall order comprehensive urine toxicology (UTOX) screen and await results.
- V. Staff shall immediately send residents requiring Narcan to Emergency Department (ED);
 - Provider shall request urine toxicology (UTOX) screen from ED and await results:
 - Charge Nurse to complete Unusual Occurrence and submit to Quality Management (QM)f or any resident requiring administration of Narcan.
 - Nurse Manager/ Nursing Operations or Quality Management (QM) shall report Facility Reported Incident (FRI) to CDPH within 24 hours per Title 22;
 - Pharmacy shall review results of any non-prescribed medications identified in UTOX with provider and notify Quality Management (QM).

2. Urine toxicology (UTOX) Results

- a. If UTOX results are negative and/or contain the residents prescribed medications no follow up required;
- b. If UTOX results are positive
 - Charge Nurse to complete Unusual Occurrence Report, AND
 - Nurse Manager/ Nursing Operations or Quality Management shall report Facility Reported Incident (FRI) to CDPH within 24 hours per Title 22.
 - Pharmacy shall review results of any non-prescribed medications identified in UTOX with provider and notify QM.
- If the RCT determines reasonable grounds exist, a designated team member may conduct a clinical safety check of the resident's person, room, bed and belongings for the safety of the resident, other residents, and staff as outlined in LHHPP 22-12 Clinical Search Protocol. All contraband found during a clinical safety check shall be turned over to the SFSD for appropriate legal disposition. If the resident becomes aggressive or poses a safety risk, unit staff shall request the SFSD to standby during the clinical safety check.
- The employee who discovers or suspects the illegal use, possession, solicitation and/or distribution shall complete an Unusual Occurrence report.

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y.b LHH staff may request the SFSD to consider a legal search.

- If warranted, the SFSD shall evaluate the circumstance and shall determine if legal "probable cause" exists to permit a deputy to conduct a legal search.
- If probable cause exists, LHH staff shall inform the resident of the need for the SFSD to search in order to protect the resident, as well as others from the health/safety implications of substance use in LHH.
- The SFSD shall conduct the legal search.
- The SFSD shall seize all contraband found during a legal search and shall proceed with appropriate and legal disposition.
- Any resident or visitor in possession of illegal substances is subject to detention and possible citation or physical arrest by the SFSD.
- vi. <u>c.</u> Substance use (lab documented and/or reasonable grounds), possession, solicitation and/or distribution shall result in progressive interventions for the resident.
 - A determination shall be made of the resident's decision-making capacity to enter into a treatment plan.
 - If resident has no decision-making capacity regarding substance treatment:
 - The RCT, in conjunction with the surrogate decision maker (if any), shall initiate or increase behavioral interventions intended to limit resident access to illicit or prohibited diverted drugs; and
 - Staff shall document reason(s) for treatment decision(s).
 - If resident has decision-making capacity regarding substance treatment:
 - Further treatment at LHH shall require that the resident adhere to a substance use related behavior plan developed by the RCT.
 - The behavioral plan may include (but not be limited to) interventions such as: random laboratory (preferably urine) toxicology testing, attendance at substance use treatment groups, restricted community or LHH access, room observation and visitor check-in.
 - Refusal to enter into a treatment contract or violation of the predetermined terms of the behavior plan shall be considered a decision by the resident to end the treatment and may result in discharge.
 - In the event of discharge, the resident shall be offered a referral to community outpatient services.

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- In the event that discharge from LHH would constitute a medical emergency (risk to life, limb or function within 48 hours), the RCT shall initiate or increase behavioral interventions intended to limit resident access to illicit or prohibited_diverted_drugs and may implement other behavior plan conditions.
- d. Upon presentation to LHH of a resident previously discharged for violation of_policies __or contract(s), a readmission to LHH shall require the resident to reengage in a substance use treatment plan. If two LHH admissions have resulted in substance use-related discharges, the resident shall be considered to have refused LHH services and, in conjunction with LHH Screening Committee, the resident shall not be readmitted without review and demonstration of change from the resident (for example, successful completion of community residential substance treatment program).

2. Paraphernalia Possession/Use by Residents

- a. When any LHH staff member has reasonable grounds to conclude a resident may have possession and/or use of drug paraphernalia, the RCT shall be informed.
 - i. Assigned nursing staff and other available members of the RCT may initiate a clinical safety check of the resident's person, room, bed and belongings for
 - i. the safety of the resident, other residents, and staff as outlined in LHHPP 2212 Clinical Search Protocol. If the resident becomes aggressive or poses a safety risk, unit staff shall request the SFSD to standby during the clinical safety check.
 - ii. The RCT may request the SFSD to consider a legal search, and to proceed, if warranted, as outlined in paragraph 1.C.IV.
- b. If staff find illicit or prohibited_diverted_drugs and/ or paraphernalia in a resident's possession and/or use:
 - i. Staff shall confiscate the illegal or prehibited_diverted drugs and/or paraphernalia and turn it over to the SFSD. ParaphernaliaSyringes not placed into evidence by the SFSD shall be disposed of in accordance with appropriate disposal procedures.
 - ii. The staff person who directly observed the drug paraphernalia shall report the incident to the SFSD.
 - iii. The clinical staff person who directly observed the drug paraphernalia, or her/his immediate supervisor, shall document the incident in the resident's medical record and complete an Unusual Occurrence report.
 - iv. If the staff member who directly observed the drug paraphernalia is not a clinician, s/he should report to an RCT member and also complete an Unusual Occurrence report.

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- v. Depending on the type of intervention (legal search or clinical safety check), the SFSD or assigned nursing staff with other available members of the RCT, may perform further checks of the resident's person, room, bed, and belongings.
- vi. If the resident remains at LHH and the physician determines reasonable grounds exist, the physician may order <u>urine or blood toxicology comprehensive drug</u> screens which shall be obtained from the patient, consistent with the signed Conditions of Admission.
- vii. Residents who are found with illegal or <u>diverted prohibited</u> drugs <u>may be subject to detention and/or citation or physical arrest by the SFSD.</u> <u>paraphernalia,including unauthorized syringes, are subject to detention and/or citation or physical arrest by the SFSD.</u>
- viii.vii. Unauthorized syringes found on or near a person may be seized by the SFSDand may result in criminal charges.
- ix.viii. Found illicit or diverted drug or paraphernaliaprohibited drug paraphernalia, including unauthorized syringes, are may be grounds for discharge.
- x.ix. If the RCT determines that the resident is unable to be immediately discharged because such discharge might constitute a medical emergency (i.e., risk to life, limb or function within 48 hours), the resident shall not be discharged. In lieu of discharge, LHH staff shall take appropriate steps to limit resident access to drug paraphernalia by creating a behavior plan that may include:
 - Restriction to room and/or neighborhood.
 - Restriction of visitors.
 - Transfer of room assignment for increased safety.
 - Removal of other personal containers where syringes could be stored (e.g., toothbrush holder).
 - Search and removal of contraband as outlined in LHHPP 22-12 (Clinical Search Protocol,)
 - Close observation by staff (refer to LHHPP 24-10 Close Observation).
 - Limitations of pass privileges.
 - Toxicology screens and resident clinical safety checks shall be performed upon return to care unit from pass, as indicated.
- c. A resident who was previously discharged for drugs or paraphernalia possession who then requests readmission to LHH and agrees to abide by LHH policies:

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- i. Shall be screened and may be considered for readmission based on his/her current condition.
- ii. May be asked to sign a behavioral plan as a condition of admission.

3. Illicit or Prohibited-Diverted Drugs and/or Paraphernalia Possession/Use by Visitors

- a. If a visitor is observed, or reasonably suspected, to be in possession and/or use of illegal or prohibited diverted drugs and/or paraphernalia, the staff who directly observed the event shall immediately report the incident to the SFSD for immediate response and investigation.
- b. A visitor found to be in possession and/or use of illicit or prohibited diverted drugs and/or paraphernalia may be referred by the RCT or LHH staff to Administration for administrative review, which may include restriction or removal of visitation privileges at LHH.
- c. A visitor found to be in possession and/or use of illegal or <u>diverted drugs and/or prohibited</u> <u>drugs or paraphernalia</u> is subject to detention, removal from LHH grounds and/or possible citation or physical arrest by the SFSD.D.

C.

ATTACHMENT:

Appendix I: Process Map for Change in Condition Rrequiring UTOX.

None.

REFERENCE:

LHHPP 20-01 Admission to LHH and Relocation Between LHH SNF Units

LHHPP 20-10 Transfer and Discharge Notification

LHHPP 22-03 Resident Rights

LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss

LHHPP 22-12 Clinical Search Protocol

LHHPP 24-10 Close Observation

LHHPP 24-25 Harm Reduction

LHHPP 60-04 Unusual Occurrences

LHHPP 75-03 Disorderly or Disruptive Visitors

MSPP D08-07 LHH Substance Treatment and Recovery Services

MSPP D08-10 Behavioral Management Services by LHH Psychiatry

Revised: 98/04/01; 00/05/25, 12/09/25, 14/05/27, 17/06/01, 17/09/12, 19/03/12, 20/05/12

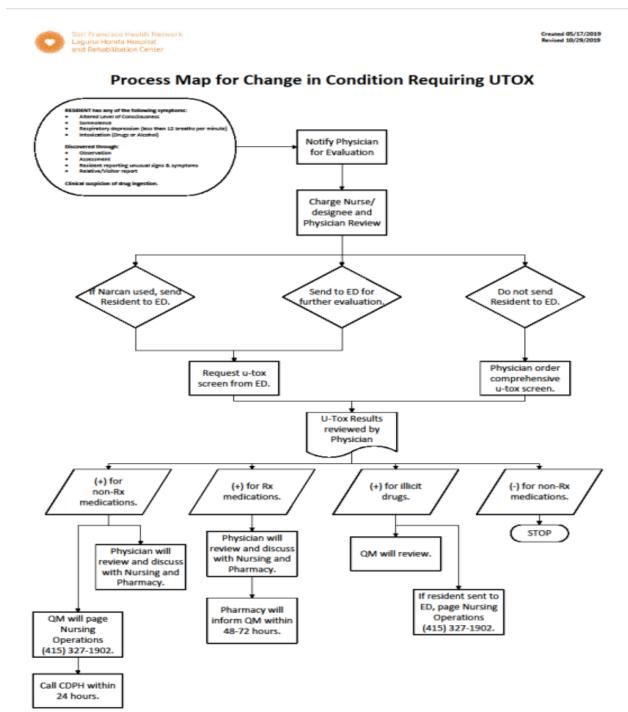
(Year/Month/Day)

Original adoption: 96/07/15 (drugs only)

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Appendix I: Process Map for Change of Condition Requiring UTOX



Revised Environmental Services Policies and Procedures

X. EQUIPMENT, SUPPLIES AND CHEMICALS

POLICY:

The <u>Environmental Services Housekeeping</u> Department will maintain adequate supplies, equipment and cleaning chemicals for the efficient operation of the Department and Hospital.

PURPOSE:

To allow the Housekeeping Environmental Services Department to carry out its function and to maintain a clean and safe the Hospital environment. in a clean, sanitary and orderly fashion.

PROCEDURE:

All cleaning chemicals used will be purchased and approved by Safety, and Infection Control Committees and procured from sources approved by the City. Cleaning chemical use, disposal and/or diluted disposal will comply with all City, State and Federal regulations. All equipment and supplies will be of good quality and procured from sources approved by the City. Equipment and its use will comply with City, State and Federal regulations. An example would be UL approved and electrical equipment.

Records will be kept of requisitions for supplies and equipment. Equipment operating instructions and warranties will be kept until that piece of equipment is replaced or discarded. Equipment will be maintained at all times.

All cleaning chemicals used will be of good quality, their purchase approved by Safety, and Infection Control Committees and procured from sources approved by the City. Cleaning chemical use, disposal and/or diluted disposal will comply with all City, State and Federal regulations.

Records will be kept of requisitions for cleaning chemicals. MSDS (Material Safety Data Sheets) will be maintained for all chemicals in use and for chemicals used, but not currently in use.

Equipment, supplies and cleaning chemicals shall not be removed from the Hospital.

A. Cleaning Cart Set-Up

To provide the EVS porter with a checklist of equipment and supplies that will be needed to complete a routine job assignment. (Project work assignments will require different and/or equipment and supplies).

1. The following items should appear on a properly equipped cleaning cart:

Materials

- 1 Wet Mop Handle
- 1 Microfiber Dust Mop Handle with 12 Head
- 1 string mop handle with
 1 microfiber string mops
- 5 or more Wet Mop Heads 14 microfiber Mops
- 24 Mop Buckets with Wringer
- 1 High Duster Handle
- 2 High Duster Heads
- 63-Wet Floor Signs

<u>Materials</u>

- 1 Caddy
- 1 Lobby Dust Pan with Broom
- CMicrofiber ragsleaning Rages
- Putty Knife
- Eye Goggle
- Gloves
- Plastic Bags (clear, black, red)
- Toilet Swab Holder
- Disposable Dust Clothes
- Liquid Hand Soap

ProductsChemicals

- Glance: Glass & Surface Cleaner
- Virex 256 Disinfectant Cleaner
- Stride: daily cleaner for non-patient floors and other hard surfaces
- Crew: Non-Acid Bowl and Bathroom Disinfectant
- Oxivir 1: Disinfectant Wipes

Previous Revisions: May 97, Jan. 07, June 2010

- 1 Toilet Bowl Swab
- 1 Toilet Grout Brush
- Hand Paper Towels
- Toilet Paper
- Toilet Seat Covers
- Trap Duster
- 2. The EVS porters are expected to keep cleaning carts clean and <u>organized orderly</u> at all times.
 - Top shelf of cart must be kept clear of cleaning supplies. except for a few clean cleths. No large containers, personal belongings or food are allowed on the cart.
 - Two mop buckets with wringers should be on the cleaning cart.
 - Soiled cleaning rags should not be seen on the cart or allowed to accumulate. They
 should be wrapped on clear plastic bags and dropped through the soiled linen chutes or
 stored in the Janitor Closets until the end of shift.
 - Extra plastic bags should be kept in the pouches on the exterior of the cart bag. Do not drape bags on the exterior of the cart.
- All cleaning solutions should be in properly labeled bottles that are clear and readable. All
 ready to use cleaning products should be in bottles with flip-top caps for dispensing cleaning
 products.
- 4. Carts will be inspected randomly by a supervisor or manager. All carts will be checked for proper cleanliness, assigned/tagged equipment and operation.

Cleaning Chemical Products

| Product | Color | Usage | PPE | Disposal |
|--------------------------------------|------------|--|-------------------|--------------------------------|
| Virex 256 Disinfectant Cleaner | Light Blue | One-Step Disinfectant Cleaner and Deodorant to clean all fixtureshigh touch areas, bed/bed frame, mattress, wardrobes, bedside stands, doors, floors and walls. Ten minute contact time. | Gloves Goggles | In accordance with local codes |
| Oxivir 1 | Wipes | Disinfectant wipe used for horizontal and vertical surfaces. One minute contact time. | Gloves | In accordance with local codes |
| Crew | Green | Non-Acid Bowl and Bathroom Disinfectant Cleaner to clean restroom toilets, sinks, urinals, under-pipes, etc. 10 minute contact time | Gloves Goggles | In accordance with local codes |
| Glance | Blue | Glass and multi-Purpose Cleaner NON-Ammoniated to clean mirror, chrome and glass surfaces. | Gloves Goggles | In accordance with local codes |
| Stride | Light red | Citrus Neutral Cleaner to clean <u>daily use on floors</u> , <u>walls</u> . <u>non-patient floors</u> and other hard surfaces | Gloves Goggles | In accordance with local codes |

XII. <u>TRANSMISSION-BASED PRECAUTIONS Cleaning Policy</u>Non-Daily Cleaning Policy

A. ISOLATION Room Cleaning

D efinition of Isolation:

Isolation is the separation patients prevent direct/indirect spread of disease and contamination

<u>Purpose:</u> Purpose: To prevent reduce the likelihood of transmission of infection by actual contact, direct or indirect.

- To reduce exposure to resident and staff from potentially harmful pathogens and to provide a clean environment that promotes health and sense of well-being for the resident. To prevent cross contamination
- To protect patients from secondary infections.
- To prevent staff from contracting diseases.

1. Minimum Cleaning Procedure Includes:

On a daily basis, Environmental Services participates as follows: Trash Pick Up:

- The Porter removes trash from room. isolation unit.
- Place in red bags and transport to biohazard waste storage room.
- If a special pick up of contaminated Biohazardous trash is needed (apart from scheduled pick up) it may be arranged by phoning request to EVS Office.

Material Recommended:

For Floor surfaces: Bleach Germicidal Cleaner

For Hand Wash: Provon Soap

For Horizontal and Vertical Surfaces High Touch Surfaces: Neutral Cleaner and Bleach Germicidal Wipes.

PPE- <u>Perform Hand Hygiene and don appropriate PPE'S for contact, droplet, or airborne precaution Gloves, hair cover, goggles, gown, shoe covers.</u>

- a. Put on gown, mask and rubber gloves.
- b. Carry into unit clean red plastic bags for trash removal and clean cleaning cloths.
- c.a. Trash removal and Dusting-
 - High Dusting of the room, starting from top of the walls and windows
 - Dusting vertical surfaces onto floor.
 - Empty trash into plastic bag. Remove trash liner from wastebasket
 - Tie off plastic bag.trash liner
 - Wash interior and exterior of wastebaskets with <u>Neutral Cleaner and Bleach</u> <u>Germicidal Wipesgermicidal detergent solution.</u>
 - Allow time for wastebaskets to completely air dry
 - Reline wastebaskets (if liners are used)

d.b. Furniture/High Touch areas— clean everything in room except bed, stand and over-bed table, as this is for — Denursing.—not touch bed or linens on beds.

Clean all high touch surfaces twice. Light switches, walls, doors and door knobs, wall mounted items, Clean with Neutral Cleaner, and after 1 minute clean again with

Previous Revisions: May 07, Jan. 07, June. 2010

germicidal beach wipes. Damp dust with clean cloth and germicidal disinfectant solution all surfaces. Mirrors, glassware and metal only need to be wiped dry with clean cloth.

e.c. Bathroom or Toilet

- Wash sink, tub, outside of toilet bowl, mirror, fixtures, pipes, toilet seat and dispensers with germicidal disinfectant solutions.
- Wipe dry with paper towel or clean cloth, the toilet seat and mirror.
- Remove water from toilet bowl by forcing over trap with applicator. Remove excess
 water from applicator by pressing against side of bowl,. Flush fixture and rinse out
 applicator. Follow Seven Step procedure when Cleaning Bathrooms. Clean all high
 touch areas noted in section b, along with mirrors, fixtures, pipes, toilet seat, and
 dispensers in bathroom twice with Neutral Cleaner and after 1 minute and Germicidal
 Bleach Wipes

f.d. Floor Care

- Wet mop bathroom, and patient room floors Sweep resident room and mop with Germicidal Bleach.
- -Sweep bathroom and mop with Germicidal bleach.
- Clean bucket, wringer and mop. Always clean equipment when finished so it will be ready for use when needed.

g.e. Leaving Room

- •
- Using proper doffing technique to reduce pathogen transmission and avoid contamination, rRemove gown, mask, and glove,s. Carefully (follow technique given by Nursing) and place in trash container discard into contaminated linen bag.
- Wash hands thoroughly with Provon Soap before proceeding to next station or assignment. Use enough scrub solution to fill cup of hand scrub from fingertips to elbows. Rinse and repeat with scrub brush.
- .<u>Clean bucket and wringer in porter closet dispose of mops in soil mop container in biohazard room.</u>

B.A. Discharge Cleaning Policy

Please See Hospitalwide Policy 20-12 Discharge Cleaning for reference

1.

Previous Revisions: May 07, Jan. 07, June. 2010

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Revised Medical Staff Policies and Procedures

PSYCHIATRIC EMERGENCIES

POLICY:

LHH residents who require acute psychiatric attention shall be attended to in a timely manner.

PURPOSE:

To assure that acute psychiatric issues or crisis situations are addressed appropriately in a timely manner.

Policy Number **D 08-01**

Revised: Marchy 145,

DEFINITION:

A psychiatric crisis is an emergency condition in which thoughts, feelings, or actions are seriously disturbed and require immediate therapeutic intervention(s) to prevent injury, deterioration of health, or loss of life. Crises may include violent or destructive behavior, or serious threats of such behavior, aimed at self or others; crises may also include nonviolent behaviors that place an individual in imminent danger (e.g., insistence on leaving "against medical advice" even though an individual has no means to provide food, clothing, or shelter).

PROCEDURE:

- 1. LHH Psychiatry providers shall be contacted by a physician when there is a psychiatric crisis. See policy MSPP-D08-03, Access to LHH Psychiatry Services. During regular business hours, LHH Psychiatry Urgent Pager (415-327-5130) may be contacted. During afterhours/weekends/holidays, the on-call psychiatrist may be contacted per posted call schedule.
- 2. If a psychiatric crisis situation occurs or is developing and it is the opinion of Primary Physician, the LHH Psychiatry provider, and/or the Chief Medical Officer (CMO) that the resident cannot be adequately cared for at LHH, the CMO or designate, or the LHH Psychiatry licensed provider shall notify the Psychiatric Emergency Service (PES) clinician/psychiatrist of the day to discuss the case and arrange for an emergency evaluation.
- 3. If a resident (who is NOT LPS conserved) is assessed as a danger to others, or to himself or herself, or gravely disabled, as a result of a mental disorder, and is in need of a psychiatric evaluation at PES, the LHH 5150 Guideline (Attachment 1) should be followed.
- 4. If the PES clinician/psychiatrist of the day does not agree to a transfer, the case will be referred to the Chief of Psychiatry or Chief Medical Officer for immediate consideration.
- 5. Close observation measures and/or North Mezzanine placement are not intended for residents who are actively suicidal or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting. (Also see LHHPP 24-10 Close Observation.)
- 6. If a resident is transferred to Psychiatric Emergency Services, a LHH Psychiatry licensed provider must evaluate the resident (either by phone report with PES clinician/psychiatrist,

Laguna Honda Hospital & Rehabilitation Center **Medical Staff Policy and Procedure** 204920

or by in-person assessment) <u>for behavioral risks, pp</u>rior to the resident returning to LHH. <u>Both the LHH Psychiatry provider and the attending physician must agree to the return. The attending physician makes the ultimate decision as to taking the resident back or not.</u> Disputed cases shall be referred to the Chief of Psychiatry or Chief Medical Officer.

Policy Number **D 08-01**

Revised: Marchy 145,

ATTACHMENT:

LHH 5150 Guideline

REFERENCE:

LHHPP 24-10 Close Observation LHHPP 22-10 Management of Resident Aggression

Approved: 01/28/14, 5/14/19: 03/05/20

Revised: 09/16/10, 09/24/13, 01/28/14, 5/14/19, 03/05/20

ATTACHMENT: LHH 5150 Guideline

Definition:

5150 Criteria: When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Health Care Services as a facility for 72-hour treatment and evaluation California Welfare and Institution Code 5150-5157.

Policy Number **D 08-01**

Revised: Marchy 145,

Overview:

- 1. At Laguna Honda Hospital, the 5150 procedure, i.e. the Application for 72-Hour Detention for Evaluation and Treatment (MH 302 form) and the Involuntary Resident Advisement (MH 303 E/S form) can be completed by either a mental health provider trained and certified by the Department of Public Health in the 5150 process, or a Sheriff's deputy.
- 2. 5150 is for a resident [who has been assessed, that **as a result of a mental disorder**, s/he is dangerous to self (DTS), dangerous to others (DTO), or gravely disabled (GD)+1 to receive **psychiatric evaluation** at a designated facility (ZSFG PES or otherwise directed). Sometimes ZSFG PES may request that the resident be medically cleared first, either by a LHH physician or by the ZSFG MER.
- 3. If a resident's acute behavioral distress is due to a medical condition, the Resident Care Team (RCT) must follow the procedures for medical emergencies, not 5150.
- 4. During after hours, the on-call psychiatrist should be contacted about a potential 5150. The psychiatrist may come in if needed to complete the procedure. If the resident is dangerous to others, the Sheriff's deputy must be called, who may initiate 5150 as indicated.
- 5. 5150 is not necessary for residents who are already on a LPS conservatorship. In those instances, the resident may be transferred to ZSFG PES/MER with a copy of the LPS conservatorship document.

Procedure:

This protocol is to be followed when a LHH resident in acute behavioral or psychiatric distress is assessed as meeting 5150 criteria, either by a mental health professional trained in the 5150 process, or by a Sheriff's deputy.

1. The LHH Psychiatry provider, in conjunction with the resident's primary physician/designee, will determine where the resident needs to go (usually ZSFG-PES, with or without medical clearance through ZSFG-MER first)

| ACUTE CARE SITE | PHONE | FAX |
|-------------------------------|-------------------------|-------------------------|
| ZSFG-PES | <u>628</u> 415-206-8125 | <u>628</u> 415-206-5733 |
| ZSFG-MER | <u>628</u> 415-206-8111 | <u>628</u> 415-206-4719 |
| Other hospital as directed by | paramedics if SZFGH-PE | ES is on diversion |

2. The LHH Psychiatry provider will call ZSFG-PES (or other psychiatric acute care facility) and describe the clinical need. The following information will be included:

Policy Number **D 08-01**

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- a. Staff name, position, and contact info
- b. Resident name, DOB, Medical Record number, diagnosis
- c. Brief clinical description
- Medical condition (possible infection, stroke, etc. Direct communication from the resident's primary/covering physician may be necessary for this, definitely if the resident needs medical clearance.)
- 3. Nursing staff will do the following:
 - a. Gather the following and copy for the ambulance packet:
 - latest admission H&P
 - physician orders
 - medication sheets
 - progress notes (including the psych staff's)
 - face sheet (SSN, contact info)
 - legal documents (e.g., conservatorship status)
 - Advanced Directives if applicable
 - b. Call the ambulance companies.
 - Inform the dispatcher if the resident is violent, so they can send appropriate staff and restraints
 - If the ambulance cannot respond soon enough, staff may need to call 911
 - c. Call the Sheriff's Deputy (x4-2319, or 4-2999 if urgent) if violence or potential exists.
 - d. Notify the appropriate family members and the conservator, if applicable.
- 4. The primary/covering MD will complete the Interfacility Transfer Form and transfer order (e.g., "Transfer to ZSFG-PES"). The unit/covering MD will call the MER physician for hand off if the resident requires medical clearance from the MER.
- 5. LHH Psychiatry provider will complete the 5150 forms, and
 - a. Make copies for the medical and for the transfer packet
 - b. Give the original to the ambulance driver (Write "ORIGINAL" in contrasting ink)
 - c. Read the Advisement to the resident (if indicated, wait until arrival of ambulance)
 - c. Give a copy of the Advisement to the resident
- 6. The LHH Psychiatry staff will enter a progress note to the Electronic Health Record including the following
 - a. Diagnoses and behaviors justifying 5150
 - b. Desired outcome prior to returning to LHH e.g., "must adhere to meds," "must be LPS conserved," or "must be Riesed," etc.
 - c. Indicate if s/he is covering for another LHH Psychiatry clinician, and if so, include her/his name.
 - d. When possible, a copy of the progress note should be included in the transfer packet.

7. The medical social worker or nurse will complete the "30-Day Notice" form and inform the resident (see guidelines)

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Revised: Marchy 145,

- 8. Staff may assist the resident to get on the gurney for the ambulance as needed and if possible.
- 9. A debriefing of the event will be conducted for the unit staff or residents as needed by the RCT and LHH Psychiatry staff.
- 10. Communication about the 5150
 - a. The involved LHH Psychiatry staff will <u>informemail and/or call</u> the following information to the Chief and all staff of the LHH Psychiatry:
 - Name of the resident, unit, date/time of 5150;
 - Brief identifying information and history;
 - Brief summary of event leading to 5150, and whether the resident met criteria of DTS, DTO, or GD;
 - Conditions or criteria for reacceptance.
 - b. The involved LHH Psychiatry staff will inform the psychiatrist who will be on-call that evening and/or weekend, as well as putting the information on the Physician sign-out log as needed, so that s/he can manage any inquiries from ZSFG PES or inpatient psychiatry.

Revised Nursing Policies and Procedures

NOTIFICATION AND DOCUMENTATION OF CHANGE IN RESIDENT STATUS CONDITION

POLICY:

- 1. The Licensed Nurse will notify the physician whenever there is an unanticipated change in resident's physical, mental, or psychosocial condition indicative of decline resulting from injury, acute medical illness or resulting from progression of chronic medical conditions.
- 2. The Licensed Nurse communicates verbally using Situation Background Assessment Recommendation (SBAR) N* Method of Communication when notifying the physician.
- 3. Non-urgent clinical issues, such as unsigned orders, expired medications, non-critical medications—will be communicated to the primary care physician during regular business hours using clipboard. Hours or via secured chat in the electronic health record (EHR).
- 4. When the physician arrives to evaluate the resident, the licensed nurse will be available to provide pertinent assessment information and assist as necessary.
- 5. A urine toxicology (UTOX) screen shall be requested, as indicated, from the Emergency Department (ED), by provider any time a resident is determined to require and ED visit.
- 6. Charge Nurse to complete Unusual Occurrence and submit to Quality Management (QM) for any resident requiring administration of Narcan.
- 4.7. When there is a change in resident condition, the family or surrogate decision maker will be notified.

PURPOSE:

To provide a standardized format for nursing to inform the physician and other interested parties about various changes in resident's condition using a standardized communication method so that the resident receives timely and appropriate treatment interventions.

BACKGROUND:

A <u>change in clinical condition differs from</u> "**significant change**" <u>ias</u> defined in the RAI/MDS as a decline (or improvement) in a resident's condition that (a) will not normally resolve itself or is not self-limiting; (b) impacts more than one area of the resident's health status; and (c) requires interdisciplinary review and/or revision of the resident care plan. <u>A change in clinical condition can lead to a significant change.</u>

Reportable MDS significant changes for decline or improvement are listed below but not limited to:

- Significant change in the resident's physical, mental or psychosocial condition.
- 2. A significant change or alteration in the treatment or care plan.
- 3. A decision to transfer or discharge the resident from the facility.
- 4. Significant change of weight (5 pounds or 5% within 30 days or 10% within the last 180 days).
- 5. An untoward reaction to medications or treatments.
- 6. Any life-threatening error in medicine or treatment (any risk to the resident).
- 7. Any time the facility is unable to timely obtain or administer drugs, equipment, supplies or services as prescribed, under conditions which present a risk to the health, safety or security of the resident.

7.

PROCEDURE:

A. Physician Notification using SBARN* Method of Communication

See attached Appendix A

Family/Significant Others Notification

Notification and Documentation of File: C 4.0 May 12, 2015, Revised

Change in Resident Status

Change in Resident Status

LHH Nursing Policies and

Procedures

_1

For family notifications regarding a serious incident or change in condition, the licensed nurse and physician will discuss the situation and make a decision regarding which of them should notify family/significant other, taking into account any prior relationship with the family /significant other and the risk management implications, refer to LHHPP 24-11.

B. Reporting and Documentation

- 1. Integrated Progress Nursing Notes
 - a. Chart the date, time and name of the physician who was notified of the change in resident's condition and each subsequent attempt to notify the physician.

a.

- b. Document notification of the Nurse Manager, Nurse Supervisor, or Program Director.
- 2. Comprehensive MDS Assessment

A Significant Change of resident condition requires that a comprehensive MDS Assessment is completed no later than fourteen (14) days after the determination by the Resident Care Team (RCT) members that a significant change has occurred. After completion of MDS assessment, a special Resident Care Team Conference should be scheduled for RCT discussion.

C. Resident Change of Condition Requiring Possible Urine Toxicology Screen:

1. Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX) would include an altered level of consciousness, abnormal vital signs (RR<12), somnolence. Observable signs of intoxication as well as sign of overdose (not breathing, unresponsive, lips and fingers turning blue/grey, gurgling sounds rigid limbs), for which a code must be called.

PROCEDURE:

- 1. Provider teshall evaluate resident after staff have identified resident is exhibiting a change of condition based upon signs and symptoms communicated by staff.
- 2. A urine toxicology (UTOX) screen shall be requested, as indicated, from the Emergency Department (ED), by provider any time a resident is determined to require an ED visit.
 A urine toxicology (UTOX) screen shall be requested from the ED by provider any time a resident is determined to require and ED visit.
- 3. The Charge Nurse shall complete Unusual Occurrence and submit to Quality Management (QM) any time a resident is determined to require and ED visit.
- 4. If resident does NOT require ED visit the provider shall order comprehensive urine toxicology (UTOX) screen and await results:
- 5. Staff shall immediately send residents requiring Narcan to Emergency Department (ED);
 - a. Provider shall request urine toxicology (UTOX) screen from ED and await results:
 - b. Charge Nurse to complete Unusual Occurrence and submit to Quality Management (QM)f or any resident requiring administration of Narcan.
 - c. Per policy, Nurse Manager/ Nursing Operations or Quality Management (QM) shall reports resident send outs <u>Facility Reported Incident (FRI)</u> to CDPH within 24 hours per Title 22;
 - d. Pharmacy shall review results of any non-prescribed medications identified in UTOX with provider and notify Quality Management (QM).

6. Urine toxicology (UTOX) Results

- a. If UTOX results are negative and/or contain the residents prescribed medications no follow up required.;
- If UTOX results are positive-

Charge Nurse to complete Unusual Occurrence Report AND

- Nurse Manager/ Nursing Operations or Quality Management shall report Facility Reported Incident (FRI) to CDPH within 24 hours per Title 22;
- Pharmacy shall review results of any non-prescribed medications identified in UTOX with provider and notify QM.

APPENDIX:

Appendix A: Physician Notification Using SBARN* Method of Communication

Appendix B: Process Map for Change in Condition Requiring UTOX

REFERENCES:

RAI/MDS Manual

SBAR Tool was developed by Kaiser Permanente

http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

CROSS REFERENCE:

LHHPP File # 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care
Conference LHHPP 24-24 Nurse-Physician Communication during Quiet Hours 10
PM to 6 AM

Revised: 10/2000, 1/2006, 1/2008, 12/2009, 10/2010; 05/12/2015

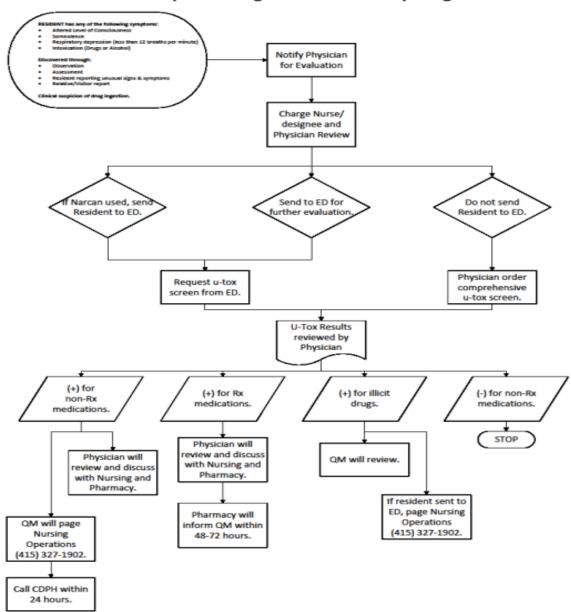
Reviewed: 05/12/2015

Approved: 05/12/2015



Created 05/17/2019 Revised 10/29/2019

Process Map for Change in Condition Requiring UTOX



OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS

POLICY:

- 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-medication refrigerator are to be locked when not in use or attended.
- 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.
- 4.5. Unless otherwise stated in this policy, the licensed nurse does not need to date products with opened date.

PURPOSE:

Correct medications will be available and stored properly.

PROCEDURES:

- A. Pharmacy Accessibility (Refer to Pharmacy Policy 01.01.01)
- B. Obtaining medication from Pharmacy
 - New medication orders will be transmitted to pharmacy as an electronic prescription via the
 electronic health record. 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 specific supply of maintenance medications to the neighborhood with scheduled oral medications.
 - b. For new ordered medication, pharmacy will dispense the amount of medication up to the next cassette cart fill 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 Policy 09.01.00).

Medication Refills

If refill is needed before routine date of replacement put empty drug container or tubes in pharmacy pick up tray. Request the refill via the EHR.

- 6. Stock Items (Refer to Pharmacy Policy 09.01.00).
- Controlled Substance Medications Pharmacy Policies 09.01.00 and 02.02.00).

C. Labeling Medications

1. The pharmacist-licensed nurse 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. If having difficulty scanning barcode of medication label, notify pharmacy of issue.

2. Label Changes:

- a. If label becomes soiled, illegible, or if change is made in <u>dosage or frequency</u> 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 the
 medication to achieve the dose, multiple strengths of medication will be sent to achieve dose.
 It is the responsibility of the LN to confirm dose prescribed with amount to be administered.

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 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 <u>24 hours</u> after expiration dates opening 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 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 carts 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 Medication refrigerator is used only for drugs needing refrigeration.
 - a. Refrigerator temperature is monitored continuously via wireless refrigerator monitoring system. The temperature log is checked twice daily by nursing staff (Refer to LHHPP 31-01: Wireless Refrigerator and Freezer Temperature Monitoring System).
 - 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

 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 LHHPP 25-05).

3-2. Hazardous Medications (formerly known as antineoplastic / cytotoxic medications)

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

4.3. Controlled Substance Medications (Refer to Pharmacy Policy 02.02.00).

5.4. Multidose Vials Injectables:

- 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
 - iv.v. The vial has met the expiration date
- b. Expiration Dating (Refer to Pharmacy Policy 02.01.06 Appendix 1).
- 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. Pharmacy assigns expiration date.
 - 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.i. Refrigerated for stability, if recommended by the manufacturer.
 - Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).

6.5. 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 <u>not</u> sent with the resident if the pharmacy is open. New orders must be placed. If the <u>pharmacy is closed</u> at the time of transfer to or from the acute care household, the nurse <u>will send</u> the medications to the receiving unit. The medications will be sent to the pharmacy for relabeling when the pharmacy opens.

7.6. Discontinued Medications:

- a. Immediately after the medication is discontinued, 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:
 - 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. All in-house medications must be returned to pharmacy after resident is 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.
- The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.

CROSS REFERENCES:

Hospitalwide Policies & Procedures

25-01 High Risk - High Alert Medications

25-02 Safe Medication Orders

25-05 Hazardous Drugs Management

31-01 Wireless Refrigerator and Freezer Temperature Monitoring System

Pharmacy Policies & Procedures

01.01.01 Accessibility to Medications

01.02.02 Stop Orders

01.08.00 Extern Students

02.02.00 Controlled Substance

02.01.06 Expiration Dating of Pharmaceuticals

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: 2010/04

Revised: 2011/03/17; 2015/07/14; 2017/01/10; 2019/05/14

Reviewed: 2019/05/14

Approved: 2019/05/14

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Revised Pharmacy Policies and Procedures

February 20192020

LAGUNA HONDA HOSPITAL DEPARTMENT OF PHARMACEUTICAL SERVICES

02.01.06

POLICY AND PROCEDURE FOR EXPIRATION DATING OF PHARMACEUTICALS

Policy:

Pharmaceutical products dispensed by the pharmacy shall be labeled with beyond-use dates.

Pharmaceutical products that expire prior to manufacturer's labeled expiration date date shall be labeled with beyond use dates. due to opening or change in storage conditions shall be assigned and labeled with an expiration date based upon the manufacturer prescribing information. These dates will be indicative of the date after which the prescription drug may not be used. This date shall be used as information on when a product should be discarded or returned to the pharmacy to be discarded. Pharmaceutical products shall not be dispensed after the expiration date on the manufacturer's container.

Purpose:

To comply with legal requirements and good clinical practice.

Procedure:

A. Repackaged unit-dose or single-unit containers:

See 02.01.09

B. Multiple-unit container for oral dosage forms(e.g. typical prescription vial):

The beyond-use dates for multiple-unit containers, such as a typical prescription vial, are not later than the expiration date on the manufacturer's container or one year from the date the drug is dispensed, **whichever is earlier**.

- C. Compounded Items:
 - 1. Non sterile compounding see 02.01.08
 - 2. Sterile compounding see 07.00.00
- D. Injectable Drugs
 - 1. Insulin and Insulin analogs
 - a) Shall be assigned a 28 day expiration date upon dispensing from the pharmacy
 - b) Shall be stored in the individual patient's cassette
 - c) Shall be visually inspected prior to use and discarded if any of the following occur:
 - (1) there is a change in appearance of the solution
 - (2) there is damage or loss of integrity of the closure
 - (3) the vial is known or suspected to be contaminated
 - 2. Sterile Multidose vials that contain a preservative (Non-Insulin)
 - a) Shall be dated upon dispensinginitial entry
 - b) Refrigerated for stability, if recommended by the manufacturer
 - c) shall be visually inspected prior to use and discarded if any of the following occur:
 - (1) there is a change in appearance of the solution
 - (2) there is damage or loss of integrity of the closure

February 20192020

- (3) the drug has been improperly stored
- (4) the vial is known or suspected to be contaminated
- d) discarded within 28 days after initially entering or opening or after 72 hours if Interlink System Vial Adapter is used on the drug vial.
- 3. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.
- 4. PPD vials shall be <u>given a 28-day expiration date-dated</u> upon initial <u>entrydispensing</u>, <u>refrigerated</u>, <u>and discarded after 28 days</u>.
- 5. Intravenous Fluids When the intravenous fluid overwrap is torn or removed any bags that are not used immediately will be dated with a sticker (obtained via central supply). The dating will be 15 days for 25 and 50 ml bags and 30 days for intravenous fluids 100 ml or larger.
- E. Non-sterile Medications and supplements without a manufacturer expiration date (such as glucose tablets) will be assigned a 3 year expiration date upon receipt in the pharmacy consistent with expiration dating regulations for ingredients without a manufacturer used in non-sterile compounding
- F. Over the counter topical preparations that do not have a manufacturer's expiration date will not be assigned an expiration date and shall be discarded by nursing if the preparation appears to be contaminated on visual inspection after opening or during use. Examples of contamination include unexpected discoloration or significant change in product consistency.
- G. See attachment 1 for medications that have special expiration dates based on storage, opening, or handling

Revision History: 6/97, 5/15/98, 8/01, 2/02, 4/03, 12/08, 9/16, 11/19, 2/20

Attachment 1 - MEDICATIONS/ DEVICES WITH SPECIAL EXPIRATION DATE REQUIREMENTS

February 2020

PHARMACY STAFF:

- For non-compounded medications not in manufacturer's packaging (in vials, bottles, etc.):
 - All repackaged medications put into pharmacy vials, bottles, etc. should be given a 1 YEAR EXPIRATION (or manufacturer's expiration date if sooner)
- PLEASE ADD EXPIRATION DATE TO LABELS ON ALL OF THE PRODUCTS BELOW AS INDICATED.

 MEDICATIONS/ DEVICES* WITH SPECIAL EXPIRATION DATE REQUIREMENTS

| Item: | Expires: |
|---|--|
| Acetylcysteine 10% Solution | If vial is opened and used, remaining solution can be |
| | refrigerated and use up to 96 hours (as labeled by pharmacy) |
| Aripiprazole oral solution | 6 months after dispensing |
| Patient specific Blood Glucose Testing Control Solutions (Patient | 90 days from opening. Dated by nursingon dispensingafter |
| Specific) | dispensing by pharmacy |
| | 2 weeks after foil pouch is opened |
| Budesonide Suspension Vials | (Upon dispensing, label each foil pouch with sticker to add date |
| | when opened) |
| Budesonide and Formoterol (Symbicort) Inhaler | 90 days after removal from foil pouchdispensing |
| Calcitonin (Miacalcin) Nasal Spray | 30 days on dispensing |
| Dakins Solution | If compounded by LHH pharmacy, expires 3 days after opening |
| | If from Century Pharmaceuticals, good |
| Dakins Solution | until the manufacturer's expiration date (see expiration date |
| | sticker on bottom of bottle) |
| Diclofenac epolamine topical patch 1.3% | 3 months after opening envelope (Upon dispensing, label each |
| | toil pouch with sticker to add date when opened)dispensing |
| Dulaglutide (Trulicity) Injection | 14 Days after dispensing if at room temperature |
| Dupilumab (Dupixent) Injection | 14 days after removal from refrigerator |
| Exanetide (Byetta and Bydureon) | 28 Days after dispensing |
| Fluticasone/Salmeterol (Advair) Diskus | 30 days after removal from foil pouchdispensing |
| Formoterol (Perforomist) nebulizer | 3 months after dispensing |
| Furosemide Solution | 90 days after dispensing |
| Glycopyrrolate/fomoterol (Bevespi Aerosphere) | 3 months after removal from foil pouchdispensing |
| Insulins (refrigerate unopened vials, open vials may be stored in | 28 days after dispensing |
| individual resident cassettes) | |
| Interlink® System Vial Adapter* | The multi-dose vial is good for 72 hours after the vial adapter is |
| | snapped on. |
| loprep Solution — | 3 days after opening |
| Ipratropium/Albuterol Respimat (Combivent Respimat) | 90 days after dispensing |
| Ipratropium Bromide and Albuterol Sulfate Inhalation Solution | 1 week after vial is removed from foil pouch |
| Irrigation Solutions(Acetic acid, NS irrigation, Irrigation G, Sterile Water) | 24 hours after opening |
| | . • |
| | 25ml and 50 ml – 15 days |
| Intravenous Fluids removed from overwrap | 100 ml or larger – 30 days |
| | Labeled by nursing when opened on nursing unit |
| Latanoprost (Xalatan) Ophthalmic | 6 weeks after dispensing |
| Levalbuterol Inhalation Solution | 2 weeks after foil pouch is opened. 1 week if vial is taken out of |
| | foil pouch |
| Liraglutide (Victoza) Injection | 30 Days after dispensing |
| Morphine (Roxanol) Oral Solution | 90 days after dispensing |
| Injection Multiple Dose Vials | 28 days after dispensing |
| Netarsudil (Rhopressa) ophthalmic solution | 6 weeks after dispensing |
| Nitroglycerin Sublingual Tablets | 6 months after dispensing |
| Olodaterol (Striverdi Respimat) | 3 months after dispensing |
| Phospholine Iodide Eye Drops | 4 weeks after dispensing at room temp |
| PPD (Aplisol or Tubersol) (refrigerate) | 28 days after dispensing |
| Salmeterol Xinafoate (Serevent Diskus) | 6 weeks after removal from foil pouchdispensing |
| Semaglutide (Ozempic) Injection | 56 Days after dispensing |
| Tiotropium (Spiriva Respimat) | 3 months after dispensing |

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| Umeclidinium (Incruse Ellipta) DPI | 6 weeks after removing from foildispensing |
|---|---|
| Umeclidinium/Vilanterol (Anoro Ellipta) DPI | 6 weeks after removing from foil dispensing |

All of the above items must be datedhave an expiration entered date on the label when opened prior to leaving pharmacy unless otherwise noted. The potency of these medications when unopened is maintained up to the expiration date on the container when stored appropriately.