ISOLATION CARTS

POLICY:
Laguna Honda Hospital and Rehabilitation Center has 6 isolation carts stored in Central Supply Room (CSR) for deployment to neighborhoods when required for isolation precautions on individual or cohorted residents. Isolation carts will be stocked with personal protective equipment (PPE) for immediate access by health care providers (HCP) while caring for patients or residents with infections requiring isolation precautions which exceed Standard Precautions. Isolation carts are not necessary when isolation rooms with anterooms for supply storage are utilized.

PURPOSE:
The purpose of this policy is to provide instructions on the procurement and use of isolation carts when required for caring for patients or residents with infections requiring precautions which exceed Standard Precautions.

BACKGROUND:
Isolation Carts are useful in promotion of best practices while caring for residents with infections in order to prevent cross contamination or infection to other residents, patients, personnel and visitors.

DEFINITIONS:

Special Contact Isolation-Synonymous with transmission based precautions based on the specific pathogen, such as Clostridium difficile.

PROCEDURE:
1. When a resident or patient is suspected or diagnosed as having an infection that requires enhanced standard precautions (ESP) or special contact isolation, the charge nurse will contact CSR and request technician staff to deliver an isolation cart to the neighborhood.

2. Prior to deployment, the isolation cart will be prepared by CSR technicians by disinfecting and stocking the cart with PPE: disposable gowns, aprons, gloves in various sizes, surgical masks, face shields, goggles, shoe covers and disinfectant wipes.
   a. Clostridium difficile and gastroenteritis precautions require hand washing with soap and water and environmental cleaning with bleach wipes, therefore hand
wipes should be removed from the isolation cart and the environmental wipes should be replaced with bleach wipes.

3. Isolation carts are to be placed outside the residents’ rooms and are to be kept clean and stocked by nursing staff while in use.

4. An envelope containing precaution and stop signs will be placed in the top drawer of the cart for selection and placement at room entrance by Nursing.

5. When precautions have been discontinued, the charge nurse or designee will contact CSR for cart retrieval from the neighborhood. Nursing staff will clean the exterior of the cart with disinfectant wipes prior to returning the cart to CSR technicians.

6. CSR Technicians will return the cart to CSR for further disinfection of cart exterior and interior, restock the cart and prepare it for use.

7. For inventory tracking of carts, CSR technicians will ensure that each isolation cart is equipped with an Aeroscout inventory tag.

ATTACHMENT:

Appendix A: Joint Infections Prevention and Control Guidelines Enhanced Standard Precautions (ESP) California Long Term Care Facilities, 2010

REFERENCE:

LHHPP 72-01 C2 Standard Precautions Policy and Procedure
www.CDC.org
www.APIC.org

Revised: N/A
Original adoption: 13/11/21 (Year/Month/Day)
RESPIRATORY PROTECTION PROGRAM (RPP)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to the protection of employees from workplace hazards by eliminating or minimizing hazards with the use of engineering and administrative controls. If engineering and administrative controls are not feasible or available to eliminate hazards posed by airborne contaminants in the workplace, employees will be provided appropriate respiratory protective equipment.

PURPOSE:

The Respiratory Protection Program (RPP) is established to protect employees from potentially hazardous airborne contaminants during the performance of their duties.

PROCEDURE:

1. PROGRAM SCOPE

This RPP applies to employees who are required to use respiratory protection on a regular basis and those who may be required to use respiratory protection in the event of a disease outbreak or other emergencies. Job classifications that are included in the RPP are listed in Appendix A. This RPP does not apply to contractors, students, volunteers, or other staff on site who are not employees of Laguna Honda, such as Sheriffs and building tenants.

In some circumstances, Laguna Honda staff may not be required to wear respiratory protection to comply with SFDPH policies, Cal OSHA standards, or CDC Guidelines, but may choose to wear a respirator for an additional level of protection. Such voluntary use is allowed for employees who are otherwise included in the RPP, and have been medically cleared, trained, and fit tested for a respirator provided by the facility.

An employee who is not covered by this RPP and would like to use a respirator must contact the Laguna Honda Industrial Hygienist or designee to be included in the RPP. Employees who are not included in the RPP such that they have not been medically cleared, trained, and fit tested shall not don a respirator while working at the facility.

The following employees who are performing the following tasks may either be required or choose to wear respirators and will be included in the RPP:
a. **Employees who are directly involved in any of the following resident care activities**

   i. Functioning in an airborne isolation room with the presence of airborne infectious disease.
   
   ii. Performing routine tasks in close proximity to residents with a known or suspected infectious disease that can be transmitted via droplet or airborne routes (meeting the definition of aerosol transmissible disease (ATD) according to Title 8 CCR Section 5199).
   
   iii. Performing high hazard procedures on residents with a known or suspected ATD.
   
   iv. Performing surge capacity functions with potential exposure to an ATD.

b. **Facility Services employees involved in the following activities:**

   i. Functioning in an airborne isolation room with the presence of an ATD.
   
   ii. Performing maintenance work that could result in exposure to an ATD.
   
   iii. Performing maintenance work that could result in exposure to other airborne contaminants such as hazardous dusts (including lead based paint), mists, oils, gases, and vapors.
   
   iv. Performing Class III asbestos spill cleanup or other work that may cause the disturbance of Asbestos Containing Material (ACM) or Potential Asbestos Containing Material (PACM).
   
   v. Responding to spills or releases of hazardous materials.
   
   vi. Performing any maintenance or emergency response duties that may cause exposure to known airborne contaminants.

c. **Other Support Services Employees (Including Environmental Services)**

   i. Functioning in an airborne isolation room with the presence of infectious disease agents.
   
   ii. Performing routine tasks in close proximity to residents with known or suspected ATDs.

d. **Health and Safety Staff**

   i. Functioning in an airborne isolation room with the presence of infectious disease agents.
   
   ii. Performing routine tasks in close proximity to residents with known or suspected ATDs.
iii. Monitoring maintenance work that could result in exposure to infectious disease agents.
iv. Monitoring the work of asbestos abatement contractors.
v. Monitoring Class III asbestos spill cleanup or other work that may cause the disturbance of Asbestos Containing Material (ACM) or Potential Asbestos Containing Material (PACM).
vi. Monitoring the removal of lead based paint or other procedures that may cause exposure of facility services employees to airborne contaminants.
vii. Responding to spills or releases of known hazardous materials.

2. PROGRAM OBJECTIVES

Laguna Honda is committed to providing a safe and healthy work environment for all employees and recognizes that respiratory protective equipment has limitations and that the success of such equipment is dependent on an effective respiratory protection program. The objectives of this RPP include:

a. Adherence to the requirements of the Cal-OSHA Respiratory Protection Standard Title 8, Section 5144, Section 5199 Aerosol Transmissible Diseases, 1529 Asbestos, and Section 1532.1 Lead.
b. Designation of an appropriate RPP Administrator to oversee and implement this program.
c. Providing a detailed outline of procedures to:
   i. Select appropriate respiratory protective equipment,
   ii. Medically evaluate employees,
   iii. Train and fit test employees,
   iv. Provide appropriate record keeping and program evaluation.

3. PROGRAM ADMINISTRATOR

The Laguna Honda Industrial Hygienist or designee shall be the RPP Administrator and will be responsible for implementation and review of the program.
## 4. RESPIRATORY PROTECTIVE EQUIPMENT SELECTION

### Table 1. Tasks Requiring Respirator Use and Selected Respirators

<table>
<thead>
<tr>
<th>Employee Group</th>
<th>Task or Duty</th>
<th>Selected Respirator</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Providers and Support Staff</td>
<td>Performing routine patient care, cleaning, or maintenance tasks in airborne isolation rooms or in the presence of residents with known or suspected ATD</td>
<td>N95 Filtering Facepiece Respirator</td>
<td>Employees are required to wear at least an N95 respirator for protection from ATDs transmissible via the airborne route (AirIDs). LHH employees may choose to use an N95 respirator for protection against ATDs categorized as transmissible via droplets.</td>
</tr>
<tr>
<td>Resident Care Providers</td>
<td>Performing high hazard procedures as defined in the ATD Exposure Control Plan.</td>
<td>PAPR with HEPA filters</td>
<td>No one except the care providers performing the procedure should be present.</td>
</tr>
<tr>
<td>Facility Services</td>
<td>Performing building repair and maintenance work that could result in exposure to hazardous airborne contaminants.</td>
<td>Half mask respirator or PAPR with the following cartridges: HEPA filters (P100) for class III asbestos work; Organic vapor cartridges for exposure to paint, solvents, oils, greases; Combination organic vapor/dust cartridge for spray painting.</td>
<td>Respirator use is required for Class III Asbestos work. Any employee doing Class III asbestos work who cannot be fit tested for a negative pressure respirator must wear a PAPR. Other repair and maintenance work is not expected to result in exposures exceeding any Cal OSHA permissible exposure limits and the use of respirators for these tasks is voluntary.</td>
</tr>
<tr>
<td>Industrial Hygienist</td>
<td>Monitoring LHH employee or contractor activities in areas where respirator use is required</td>
<td>N95 filtering facepiece. Half face respirator with appropriate cartridges.</td>
<td></td>
</tr>
<tr>
<td>Facility Services and Industrial Hygienist</td>
<td>Spill response</td>
<td>Half face respirator or PAPR with appropriate cartridge for spilled material.</td>
<td>Certain designated LHH employees may respond to small chemical spills of known materials that are not expected to result in an oxygen deficiency or exposures greater than 10 times the PEL for any substance. No LHH employee will enter an IDLH atmosphere or attempt to respond to a spill or release of an unknown material.</td>
</tr>
</tbody>
</table>

The respiratory protection equipment selection process is based on:

a. A review of work procedures.
b. Potential airborne contaminants and concentrations.
c. Cal OSHA substance-specific respirator requirements.
d. Only respirators certified by the National Institute for Occupational Safety and Health (NIOSH) will be used.

5. MEDICAL EVALUATIONS

Laguna Honda employees included in the RPP shall complete a medical evaluation prior to fit testing and equipment use to ensure they are able to perform work tasks while using a respirator. Medical evaluations shall be provided at no cost to the employee. An employee has the right to use his or her own personal physician in lieu of the designated Physician or other licensed health care provider (PLHCP)

a. Initial Medical Clearance Evaluations

Initial medical evaluation includes:

i. New Laguna Honda employees in the job classifications listed in Appendix A shall be medically evaluated for clearance to use respiratory protection during their pre-employment exam at the SFGH Occupational Health Clinic using responses to questionnaires required by Cal OSHA.

- Employees in non-resident care classifications shall be evaluated using the RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE found in Appendix B.
- Resident care job classifications shall be evaluated using the ALTERNATE RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE found in Appendix B.

ii. The PLHCP at San Francisco General Hospital (SFGH) shall complete the Medical Clearance Certificate (Appendix C) and forward it to the Laguna Honda Industrial Hygienist or designee.

iii. If an employee is not cleared for the use of a particular type of respirator, they must not be assigned to tasks that require the use of that respirator. However, if an employee is cleared to use a PAPR, but not a negative pressure respirator, they may perform tasks requiring a negative pressure respirator using a PAPR.

b. Subsequent Medical Evaluations

Subsequent medical examinations shall be provided to an employee under the following circumstances:

i. Employee reports medical signs/symptoms or a medical condition to a Supervisor that are related to his or her ability to use a respirator.

ii. Information from the RPP, including observations made during the fit testing or the program evaluation, which indicates the need for employee medical re-evaluation.
iii. The PLHCP determines that an evaluation is needed. It is DPH policy that this will include a re-evaluation every 5 years.

iv. The employee requests re-evaluation due to a change in health status.

6. TRAINING

Employees included in the RPP due to being in a job classification listed in Appendix A shall complete an initial training on respiratory protection before being assigned to a task requiring the use of a respirator. The initial training that will be completed during departmental orientation will be broken into two parts. One part will be delivered live or on the e-Learning system and the other will be hands-on training during fit testing.

a. The eLearning training module shall include:
   i. The requirements of the RPP and information on where to find the written program.
   ii. Potential airborne hazards and health consequences resulting from exposures.
   iii. Why and when respirator use is required and the risks and limitations of respirator use.
   iv. Procedures for equipment cleaning, inspections, maintenance and storage.
   v. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

b. The hands-on training shall include:
   i. How to inspect the respirator.
   ii. How to don and doff the respirator.
   iii. How to perform positive and negative pressure seal checks.

7. FIT TESTING

a. Employees shall only be fit tested if they have been medically cleared for respirator use prior to the fit test. If they are not cleared for respirator use, they must not be assigned to tasks that require respirator use.

b. Employees who are required to regularly wear a respirator shall be fit tested annually by the Industrial Hygienist or other staff designated by the Industrial Hygienist. New employees shall not be assigned to tasks requiring the use of a respirator until they have been fit tested.

c. In addition to annual testing, employees shall be re-tested if any of the following occurs:
i. Different respiratory protective equipment is introduced.
ii. The employee reports an improper fit.
iii. There is a significant change in the size or shape of an employee's face.

d. Employees who do not regularly wear respirators, but who may be required to wear one during an emergency or surge shall be fit tested as needed prior to wearing the respirator.

e. In accordance with Cal-OSHA, fit testing for a negative pressure respirator shall not be performed on any employee who has facial hair (including stubble, beard, mustache, sideburns) that interferes with the face to facepiece seal of the respirator. OSHA Compliance Directive CPL 2.120 defines the presence of facial hair to be "more than one day's growth".

f. Quantitative fit testing using a TSI PortaCount Pro or qualitative fit testing using Bitrex or Saccharin will be performed according to the protocols in Appendix A of Title 8 CCR Section 5144.

g. Employees shall be given the opportunity to choose from several brands and sizes of respirators.

h. Fit test results shall be documented on the Fit Test Certificate found in Appendix D.

i. The Industrial Hygienist or designee shall maintain a list of employees who have been fit tested within the last year showing the make and size of respirator for which they have passed the fit test. The list shall be updated at least quarterly and sent to Department Managers whose employees are required to use respirators.

8. RESPIRATORY PROTECTIVE EQUIPMENT USE

a. Requirements for Use
   i. Employees must be medically cleared, trained and fit tested before using any respiratory protective equipment.
   ii. Employees are required to use the same make, model, style and size respirator for which they have been fit tested.
   iii. Employees are prohibited from using respiratory protective equipment if they have any condition that will prevent an effective seal (e.g. facial hair, extensive scarring).

b. Procedures Before and During Use
   i. Employees must inspect equipment for integrity before use.
   ii. Employees must perform user seal checks prior to use.
iii. Employees using PAPR units must perform an airflow test prior to use.

iv. Corrective eyewear and other personal protective equipment must be worn in a manner that does not interfere with the respirator seal.

v. An employee must exit the work area to a designated safe zone if:
   - Respiratory protective equipment malfunctions or becomes damaged.
   - They experience an increased in breathing resistance.
   - They detect chemical cartridge breakthrough.

9. STORAGE, MAINTENANCE, AND DISPOSAL

a. Storage

i. N95 filtering facepiece respirators for use in patient care and cleaning of isolation rooms will be available from Central Supply and will be stored in the ante rooms of the isolation rooms when occupied by a resident with suspected or confirmed ATD. They may also be stored at the nurses’ station or equipment room in each of the units.

ii. Facility Services employees who will be required to wear respirators will be issued their own half face elastomeric respirator, which they will store in a plastic bag in their locker.

iii. The Industrial Hygienist will also be issued a half face respirator, which will be kept in a plastic bag in his/her office.

iv. PAPRs will be stored in the Facility Services Department, the Nursing Department, and the Industrial Hygienist’s Office.

b. Maintenance, Cleaning and Disposal

i. Half face elastomeric respirators

   - Elastomeric respirators will be inspected before and after use to ensure all parts are working and have not been damaged. Damaged respirators will either be repaired or replaced by the Director of Facility Services.
   - Employees who have been issued their own elastomeric facepiece will be responsible for cleaning the respirator with a disinfectant wipe or mild soap and water after each use. Respirators will be air dried and returned to a zip lock bag for storage.
   - After use, cartridges will be removed and placed in zip-lock bags.
   - Chemical cartridges will be replaced if they become damaged or when the wearer perceives breakthrough of the contaminant.
   - Filter cartridges will be replaced when the wearer notices an increased resistance to breathing.
ii. N95 filtering facepieces

- N95s are designed for single use and will be discarded when removed after exposure to a confirmed or suspected case of ATD. Re-use will only be permitted in the event of a shortage during a disease outbreak as per the ATD Exposure Control Plan.
- N95s that are used voluntarily or for non-infectious dusts may be re-used for the duration of a shift as long as they are not damaged.

iii. PAPRs

- PAPRs will be maintained fully charged in their storage locations so that they are ready for use.
- Air flow will be checked before and after use of PAPRs.
- Filter cartridges on PAPRS will be changed when they are damaged or when air flow drops below 6 cubic feet per minute (CFM).
- PAPR blowers will be cleaned with disinfectant wipes after each use. PAPR hoods will be discarded after use in atmospheres contaminated with asbestos or an ATD.

10. PROGRAM REVIEW

The Industrial Hygienist or designee shall perform annual evaluations to ensure the provisions of this program are being implemented. These evaluations will include:

a. Interviews of employees using respiratory protective equipment.
b. Observations of employees using equipment.
c. Investigation of environments in which equipment is used.
d. Review of all records.

Deficiencies and planned corrections will be included in a Respiratory Protection Program Report and provided to the Chief Operating Officer.

11. RECORD KEEPING

a. Written Program

The Industrial Hygienist or designee shall maintain a hard copy of the written RPP and records of program evaluations. An electronic copy will be available on the LHH intranet web site.
b. Medical Clearance Records

i. Confidential records including medical clearance questionnaires will be kept in the employees’ employee health medical files in accordance with the DPH Privacy Policy and Title 8 CCR Section 3204 for the duration of employment plus 30 years.

ii. Medical Clearance Certificates will be entered into the DPH OSH Respiratory Protection Database by the Industrial Hygienist or designee. Hard copies will be kept on file in the health and safety office.

c. Training Records

Training records shall be maintained by the Department of Training and Education on the eLearning system. The Industrial Hygienist or designee shall enter the training records into the DPH OSH Respiratory Protection Database.

d. Fit test Records

Fit test records shall be entered into the DPH OSH Respiratory Protection Database by the Industrial Hygienist or designee or designee. Hard copies shall be kept on file in the health and safety office until the next fit test.

ATTACHMENT:

Appendix A: Job Classifications Included in the LHH RPP
Appendix B: Medical Questionnaires
Appendix C: Medical Clearance Certificate
Appendix D: Fit Test Certificate

REFERENCE:

Cal-OSHA Aerosol Transmissible Disease Standard, 8 CCR Section 5199
Cal-OSHA Asbestos Standard, 8 CCR Section 1529
Cal-OSHA Lead Standard, 8 CCR Section 1532.1
Cal-OSHA Respiratory Protection Standard, 8 CCR Section 5144

Revised: N/A
Original Adoption: 13/11/21 (Year/Month/Day)
APPENDIX A

Job Classifications Included in the LHH RPP
<table>
<thead>
<tr>
<th>Code</th>
<th>Position</th>
<th>Code</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>2230</td>
<td>Physician Specialist</td>
<td>2585</td>
<td>Health Worker I</td>
</tr>
<tr>
<td>2232</td>
<td>Senior Physician Specialist</td>
<td>2587</td>
<td>Health Worker III</td>
</tr>
<tr>
<td>2302</td>
<td>Nursing Assistant</td>
<td>2588</td>
<td>Health Worker IV</td>
</tr>
<tr>
<td>2303</td>
<td>Patient Care Assistant</td>
<td>2593</td>
<td>Health Program Coordinator III</td>
</tr>
<tr>
<td>2305</td>
<td>Psychiatric Technician</td>
<td>2622</td>
<td>Dietetic Technician</td>
</tr>
<tr>
<td>2312</td>
<td>Licensed Vocational Nurse</td>
<td>2624</td>
<td>Dietitian</td>
</tr>
<tr>
<td>2320</td>
<td>Registered Nurse</td>
<td>2626</td>
<td>Chief Dietitian</td>
</tr>
<tr>
<td>2322</td>
<td>Nurse Manager</td>
<td>2736</td>
<td>Porter</td>
</tr>
<tr>
<td>2323</td>
<td>Clinical Nurse Specialist</td>
<td>2738</td>
<td>Porter Assistant Supervisor</td>
</tr>
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<td>2324</td>
<td>Nursing Supervisor</td>
<td>2920</td>
<td>Medical Social Worker</td>
</tr>
<tr>
<td>2390</td>
<td>CPD Technician</td>
<td>2922</td>
<td>Sr Medical Social Worker</td>
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<td>2406</td>
<td>Pharmacy Helper</td>
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<td>Medical Social Work Supv</td>
</tr>
<tr>
<td>2409</td>
<td>Pharmacy Technician</td>
<td>3417</td>
<td>Gardener</td>
</tr>
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<td>2424</td>
<td>X-Ray Laboratory Aide</td>
<td>6138</td>
<td>Industrial Hygienist</td>
</tr>
<tr>
<td>2430</td>
<td>Medical Evaluations Assistant</td>
<td>7120</td>
<td>Buildings/Grounds Maint Supv</td>
</tr>
<tr>
<td>2450</td>
<td>Pharmacist</td>
<td>7203</td>
<td>Buildings/Grounds Maint Supv</td>
</tr>
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<td>2454</td>
<td>Clinical Pharmacist</td>
<td>7205</td>
<td>Chief Stationary Engineer</td>
</tr>
<tr>
<td>2468</td>
<td>Diagnostic Imaging Tech II</td>
<td>7334</td>
<td>Stationary Engineer</td>
</tr>
<tr>
<td>2469</td>
<td>Diagnostic Imaging Tech III</td>
<td>7335</td>
<td>Sr Stationary Engineer</td>
</tr>
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<td>2536</td>
<td>Respiratory Care Practitioner</td>
<td>7342</td>
<td>Locksmith</td>
</tr>
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<td>2542</td>
<td>Speech Pathologist</td>
<td>7344</td>
<td>Carpenter</td>
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<tr>
<td>2548</td>
<td>Occupational Therapist</td>
<td>7345</td>
<td>Electrician</td>
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<tr>
<td>2550</td>
<td>Sr Occupational Therapist</td>
<td>7346</td>
<td>Painter</td>
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<tr>
<td>2554</td>
<td>Therapy Aide</td>
<td>7347</td>
<td>Plumber</td>
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<td>2555</td>
<td>Physical Therapist Assistant</td>
<td>7524</td>
<td>Institution Utility Worker</td>
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<td>2556</td>
<td>Physical Therapist</td>
<td>P103</td>
<td>Special Nurse</td>
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<td>2558</td>
<td>Senior Physical Therapist</td>
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<td></td>
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<td>2574</td>
<td>Clinical Psychologist</td>
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<td></td>
</tr>
<tr>
<td>2576</td>
<td>Supv Clinical Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2583</td>
<td>Home Health Aide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B

MEDICAL QUESTIONNAIRES
Can you read?  

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today’s Date _________________________________
2. Your Name: _________________________________ DSW: __________________________
3. Your age (to nearest year): ______________ Date of Birth: _____________________
4. Sex (circle one)   Male / Female
5. Your height _________ ft. _________ in.
6. Your weight __________________ lbs.
7. Your job title: ______________________________________________________________
8. A phone number where you can be reached by the health care professional who reviews this questionnaire

(   )- -___________
9. The best time to phone you at this number: ________________________________
10. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐
11. Check the type of respirator you will use (you can check more than one category):
   a. ☒ X N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ☒ X Other type (for example, half-or full-facepiece type, powered-air purifying, supplied air, self-contained breathing apparatus).
12. Have you worn a respirator? Yes ☐ No ☐
13. If “yes”, what type(s)? _________________________________________________
PART A. SECTION 2. Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check “yes” or “no” to answer each question).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
   Yes ☐ No ☐

2. Have you ever had any of the following conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Seizures (fits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Diabetes (sugar disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Allergic reactions that interfere with your breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Claustrophobia (fear of closed-in places)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Trouble smelling odors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Have you ever had any of the following pulmonary or lung problems?

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Asbestosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Chronic bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Silicosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Pneumothorax (collapsed lung)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Lung cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Broken ribs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Any chest injuries or surgeries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Any other lung problems that you’ve been told about</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Do you currently have any of the following symptoms of pulmonary or lung illnesses?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Shortness of breath when walking with other people at an ordinary pace on level ground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Have to stop for breath when walking at your own pace on level ground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Shortness of breath when washing or dressing yourself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Shortness of breath that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Coughing that produces phlegm (thick sputum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Coughing that wakes you early in the morning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Coughing that occurs mostly when you are lying down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Coughing up blood in the last month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Wheezing that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Chest pain when you breathe deeply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Any other symptoms that you think may be related to lung problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Have you ever had any of the following cardiovascular or heart problems?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Heart attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Angina</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Swelling in your legs or feet (not caused by walking)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Heart arrhythmia (heart beating irregularly)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Any other problems that you’ve been told about</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Have you **ever** had any of the following cardiovascular or heart symptoms?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Frequent pain or tightness in your chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Pain or tightness in your chest during physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Pain or tightness in your chest that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. In the past two years have you noticed your heart skipping or missing a beat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Heartburn or indigestion that is not related to eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Any other symptoms that you think may be related to heart or circulation problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Do you **currently** take medication for any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Breathing or lung problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Seizures (fits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Other medical condition(s) please describe:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. If you’ve **ever** used a respirator, have you **ever** had any of the following problems?
   (If you’ve **never** used a respirator, check the following space… □… and go to question 9).

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Eye irritation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Skin allergies or rashes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. General weakness or fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Any other problems that interferes with your use of a respirator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Would you like to talk to the health professional who will review this questionnaire?
   
   Yes □  No □
To the PLHCP: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the employee: Can you read and understand this questionnaire (circle one): Yes  No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today’s date: __________________________
Name: ___________________________ DSW: ____________________
Job Title: ____________________________
Your age (to nearest year): ________________
Sex (circle one): Male  Female
Height: ______ ft. ______ in.  Weight: ________ lbs.
Phone number where you can be reached (include the Area Code): ( ) ______________
The best time to phone you at this number: __________________________

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes  No

Check the type of respirator you will use (you can check more than one category):

X  N, R, or P disposable respirator (filter-mask, non-cartridge type only).
X  Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA). (fill in type here) PAPR

Have you worn a respirator (circle one): Yes  No
If "yes," what type(s): _________________________
Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Have you ever had any of the following conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic reactions that interfere with your breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claustrophobia – fear of closed in spaces</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Do you currently have any of the following symptoms of pulmonary or lung illness?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath when walking fast on level or walking up a slight hill or incline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have to stop for breath when walking at your own pace on level ground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing up blood in the last month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain when you breathe deeply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other symptoms that you think may be related to lung problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Do you currently have any of the following cardiovascular or heart symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent pain or tightness in your chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain or tightness in your chest during physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain or tightness in your chest that interferes with your job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other symptoms that you think might be related to heart or circulation problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Do you currently take medication for any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing or lung problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat or sinuses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are your problems under control with these medications?  
Yes  No

5. If you've used a respirator, have you ever had any of the following problems while respirator is being used? 
(If you've never used a respirator, check the following space and go to question 6:)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin allergies or rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General weakness or fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other problem that interferes with your use of a respirator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?  
Yes  No

_______________________________________________________  
Employee Signature  
Date

_______________________________________________________  
PLHCP Signature  
Date
Part I: To be completed by RPP Administrator or employee’s supervisor

Job Category(s):

- Resident Care
- Disaster Service Worker
- Asbestos/Lead/Hazmat
- Construction/Maintenance
- Occupational Safety & Health
- Other: ______________________

Respirator Type(s):

- Filtering Facepiece (N95, N100, P100)
- Powered Air Purifying Respirator (PAPR) with loose hood
- Half Face Air Purifying
- Other: ______________________

Duration of Use:

- <1 hour
- 1-4 hours
- 4-8 hours
- 8-12 hours
- Other: ______________________

Frequency of Use:

- Regularly (daily)
- Frequently (few times per week)
- Occasionally (few times per month)
- Rarely (few times per year)
- No regular use – only in a surge or emergency
- Other: ______________________

Level of Work Effort:

- Light (sitting standing, light arm work)
- Moderate (walking with moderate lifting)
- Heavy (strenuous work, shoveling)
- Other: ______________________

Working in extreme temperature or humidity?:

- Yes
- No
Part II: To be completed by the physician or other health care provider (PHLCP) for respirator types indicated in Part I.

<table>
<thead>
<tr>
<th>Name of PHLCP:</th>
<th>Evaluation Date:</th>
</tr>
</thead>
</table>

### Filtering Facepiece (N95, N100, P100)
- [ ] Medically qualified to wear this type of respirator
- [ ] Medically qualified to wear this respirator with the following restrictions:
  - ![Text box for restrictions](#)
  - ![Text box for restrictions](#)

- [ ] Not Medically qualified to wear this type of respirator

### Powered Air Purifying Respirator
- [ ] Medically qualified to wear this type of respirator
- [ ] Medically qualified to wear this respirator with the following restrictions:
  - ![Text box for restrictions](#)
  - ![Text box for restrictions](#)

- [ ] Not Medically qualified to wear this type of respirator

### Half Face Air Purifying Respirator
- [ ] Medically qualified to wear this type of respirator
- [ ] Medically qualified to wear this respirator with the following restrictions:
  - ![Text box for restrictions](#)
  - ![Text box for restrictions](#)

- [ ] Not Medically qualified to wear this type of respirator

PHLCP Signature

Send this form to Kate Durand, Industrial Hygienist, Laguna Honda Administration – Fax: 415-759-2374
Laguna Honda Hospital

FIT TEST CERTIFICATE

APPENDIX D

FIT TEST CERTIFICATE
Laguna Honda Hospital

FIT TEST CERTIFICATE

Employee Name: ___________________________________________ Date: __________________ 

DSW: __________________________ Medical Clearance Date: __________________________ 

Respirator Manufacturer: ________________________________ 

Respirator Type: ______________________ Model Number: __________ Size: __________ 

Test Results

<table>
<thead>
<tr>
<th>Activity</th>
<th>Qualitative Test Pass/Fail</th>
<th>Quantitative Test Fit Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head side to side</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head up and down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grimace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Test Score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fit Tester: ____________________________ Print ____________________________ Sign ____________________________

I understand that I have been fitted for the respirator indicated on this form and that I should always wear this make and model of respirator. I have been trained on how to don and doff the respirator and how to perform a seal check each time I wear it.

Employee: ____________________________ Print ____________________________ Sign ____________________________
ADMISSION TO LAGUNA HONDA AND
RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) 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. Laguna Honda will comply with California and federal laws pertaining to non-discrimination.

1. Laguna Honda will accept and care for those San Francisco residents:
   a. who meet skilled nursing facility (SNF) or acute care criteria
   b. for whom it can provide safe and adequate care
   c. who are at least 16 years of age.

2. Applicants for admission to Laguna Honda shall be screened prior to any admission.

3. Laguna Honda 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. Laguna Honda will accept pre-scheduled admissions of new and returning patients from San Francisco General Hospital (and only SFGH) seven days a week, except holidays.

5. Laguna Honda 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.

6. Laguna Honda shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or rehabilitation services who are admitted to Laguna Honda 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:

A&E: Admissions and Eligibility Department
BCC: Bed Control Coordinator
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 Laguna Honda Hospital and Rehabilitation Center shall be given to residents of San Francisco. Exceptions may be made by the Laguna Honda Executive Administrator/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 Laguna Honda Medical Director or designee shall be responsible for screening patients for admission to Laguna Honda to ensure that the facility admits only those patients for whom it can provide adequate care. The Laguna Honda Executive Administrator is the ultimate authority over admissions. The following sequential priority will be followed unless the Laguna Honda Executive Administrator 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 Laguna Honda 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 San Francisco General Hospital 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. Laguna Honda cannot adequately care for prospective residents with the following:

      i. communicable diseases for which isolation rooms are unavailable

      ii. in police custody

      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

e. Screening of applicants:

i. The Screening Committee which includes the following: Medical Director or designee, Chief Nursing Officer or designee, Admissions Coordinator, Bed Control Coordinator and other members as designated by the Administrator, is responsible for screening referrals to Laguna Honda 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 or designee, and the Chief Nursing Officer or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the Laguna Honda Specialty Unit will ask the Laguna Honda Behavioral Assessment Team to screen potential admissions that have behavioral or psychiatric problems.

f. Admission of applicants:

i. Laguna Honda shall admit a patient only on a Laguna Honda 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 Laguna Honda 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. ¹ Residents 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 Laguna Honda Medical Director and Laguna Honda Executive Administrator for resolution.

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

h. The Laguna Honda Executive Committee 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 Laguna Honda. The Conditions of Admission agreement will be reviewed and signed by the resident or the resident’s surrogate decision-maker.

iii. The Screening Committee will make placement decisions based on the identified physical, mental, social and emotional needs of the resident and bed availability and communicate with the nursing unit and Resident Care Team including the primary physician and nurse manager admitting the new resident.

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, 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).
iv. 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.

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

b. Acute Medical Unit

Policies Specific to Acute Medical Unit

i. Only acutely ill Laguna Honda 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

iv. 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.

v. Whenever a resident is admitted to the Acute Medical Unit from either a Laguna Honda 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.

vi. 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**

v. Rehabilitation needs will include at least two 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 Acute Rehabilitation Unit.

vi. Patient requires and has the ability to engage daily in three hours of at least two of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

vii. Patients must have a reasonable plan for discharge into the community.

**Admission Criteria Specific to SNF Rehabilitation Unit**

viii. 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.

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

x. 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**

xi. 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 acute rehabilitation services.

xii. A new SNF record will be started if the patient is discharged to a Laguna Honda SNF Care Unit.

**Admission Procedures Specific to SNF Rehabilitation Unit**

xiii. 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

ii. Residents who are mobile;

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

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

v. Resident who has a conservator or legal representative that agrees to placement of the resident in a secured setting, or who is a SFGH patient or Laguna Honda resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

vi. The requirements above do not preclude Laguna Honda 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

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

Procedures Specific to Secure Memory Care Unit

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

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

x. 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.

xi. A resident of the Laguna Honda Secure Memory Care Unit will be relocated as soon as reasonably possible to other Laguna Honda 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.

xii. 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. Weekend Admissions from San Francisco General Hospital (SFGH)

a. Laguna Honda primary physician will refer SFGH team to Laguna Honda Admissions and Eligibility (A&E) once patient is accepted.

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

c. Weekend admissions must be approved by the Laguna Honda admissions screening committee, and accepted by the primary Laguna Honda team (including primary physician) by the Friday afternoon preceding admission.

d. Laguna Honda A&E will inform SFGH (UM and MSW) via Laguna Honda tracking and text page by 3pm on Friday of admissions scheduled for the weekend. Laguna Honda A&E will inform SFGH MSW of Laguna Honda primary physician's pager number.

e. Approval by Laguna Honda weekend admitting physician is not required for admission.

f. Laguna Honda 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.

g. Laguna Honda primary physician will receive clinical hand off from SFGH physician by the Friday preceding the weekend admission, and a dictated discharge summary will be available at the time of admission.

h. Laguna Honda nursing will receive report from SFGH nursing on the day of transfer.

i. Laguna Honda A&E will remind SFGH MSW to arrange ambulance transport to leave SFGH no later than 11 am.

j. Admissions are scheduled to arrive to Laguna Honda early in the day and no later than 12 noon.

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 Laguna Honda 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 Laguna Honda; 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 Laguna Honda 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 Laguna Honda 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 BCC in collaboration with the Medical Director or designee and Chief Nursing Officer or designee.

iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT will be evaluated by the BCC, 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 BCC 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 and Medical Director 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 BCC. For relocations to specialty units, the BCC 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 BCC 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:
LHPP 22-03 Resident Rights
LHPP 23-01 Development & Implementation of an Interdisciplinary Resident Care Plan
LHPP 24-06 Resident Suggestions and Complaints

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 (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:__________________________

ITEMS CHECKED: ADDRESSOGRAPH

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

CHECKED BY:
DISCHARGE PLANNING

PHILOSOPHY:
Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, Laguna Honda continually facilitates timely and safe resident discharges to the appropriate level of care.

POLICY:
1. Laguna Honda strives to assist every client/resident (hereafter "resident") achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the care team shall continue to support maximal social integration.

2. The facility provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences.

3. Residents who no longer meet skilled nursing facility (SNF) level of care and/or who SNF needs can be met a lower level of care shall be prepared for discharge into the community with supportive services.

4. Intensive discharge planning support and skills training shall be provided to the resident to assist him or her to transition from an institutional setting to community living.

5. The Resident Care Team (RCT) shall recognize that residents with decision-making capacity and or their surrogate decision-maker (SDM) have the right to decline recommended discharge options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge plan.

6. Residents with decision making capacity who repeatedly decline discharge options, or refuse to participate in discharge planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT.

PURPOSE:
To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer needs SNF services or are able to be cared for at a lower level of care.
PROCESS DEFINITION AND GUIDELINE:

1. Discharge assessment process considers:
   a. The resident's characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).
   b. The resident's values and preferences.
      i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.
      ii. The resident's self-assessment of needs and priorities may legitimately differ from that of the RCT.

2. Discharge planning:
   a. Begins during the resident's admission assessment.
   b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.
      i. A resident may need to progress through several stages of increasing independence prior to discharge.
      ii. Certain residents may be expected to leave Laguna Honda and return, perhaps repeatedly.
      iii. The experience of residents who have been at a lower level of care for one or more limited periods can lead to valuable refinements of the discharge plan.
   c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.
      i. Informed choice is a fundamental principle of service delivery.

1 Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single ‘appropriate’ setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers.” (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).
ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

iii. Residents, SDMs, caregivers, and RCT members may enlist the Ethics Committee, ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. Utilization issues:

   a. Resident independence and resource stewardship are Laguna Honda Hospital and Rehabilitation Center values that inform discharge planning.

      i. Residents shall be discharged to the lowest possible levels of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

      ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, self-care readiness, and a sense of hope for future possibilities.

4. Conservatorship and decisional capacity:

   a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

   b. Absent legal adjudication, the primary physician bears responsibility for determining if a resident has capacity to make informed choices about interventions and discharge planning.

      i. A resident may have only partial or varying capacity to make informed decisions.

      ii. Capacity determination for residents with mild-moderate impairments is a clinical art about which good clinicians may responsibly disagree.

      iii. The conservatorship process may be helpful in resolving disputes and protecting residents.

   c. A resident with capacity retains the right to make decisions that RCT members consider unwise.
i. RCT members shall educate the resident (or conservator or other SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining his/her well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall nevertheless elicit, document, and consider the resident’s current and/or past values and preferences relevant to discharge.

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

a. Laguna Honda is committed to developing collaborative relationships with other organizations in order to meet residents’ needs.

b. RCT members should be familiar with community-based services appropriate to their disciplines.

c. RCT members should seek positive collaborations with members of the resident’s informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.

PROCEDURE:

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner when the resident’s condition improves and s/he no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. The resident and or their SDM shall be educated on admission by designated members of the RCT that when their health condition sufficiently improves or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be finalized to transition the resident back to the community.

3. All discharges, with the exception of rehab service residents whose stay is less than 90 days, are planned in advance with the collaboration of the Diversion Community Integration Program (DCIP) and wrap-around community services secured prior to the resident’s discharge.
4. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Social Services Director or designee, the Utilization Management Manager or designee, the Medical Director or designee, and Chief Nursing Officer or designee shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

5. RCT Roles and Responsibilities

The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

a. RCT Responsibilities

   i. The physician, social worker, nurse, activity therapist, dietitian, with others as needed:

   ii. Perform the discharge assessment process as described and negotiate the discharge plan.

   iii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.

   iv. Encourage the resident to sustain healthy relationships and interests in the community.

   v. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.

   vi. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.

   vii. Document the resident's (and/or surrogate's) understanding of the discharge plan.

   viii. Complete the appropriate sections of the Post-Discharge Plan of Care form.

2 The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.
b. Physician

i. **Addresses the resident’s preliminary rehabilitation and discharge potential in the admission H&P.**

ii. Communicates with the resident (or surrogate), caregivers, and with RCT members regarding the resident’s conditions and expected course so that the goals of care can be adjusted as needed.

iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.

iv. Attempts to simplify the resident’s medication regimen, preferably months or weeks prior to discharge.

v. Ensures that appropriate post-discharge medical follow-up is arranged.

vi. Writes discharge order.

c. Social Worker / Targeted Case Manager (TCM)

i. Coordinates the discharge assessment process and plan.

ii. Contacts the resident’s caregivers and community-based support services to inform them of the admission, to invite them to care conferences, and to seek their collaboration.

iii. Attempts to secure the resident’s housing if discharge is possible.

iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.

v. Completes the discharge assessment instrument (MR 711), describing the resident’s needs, supports, barriers to discharge, and team recommendations. (Laguna Honda social worker only)

vi. Enters into the Laguna Honda discharge database any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.

vii. Updates the discharge assessment as needed due to pertinent changes or upon readmission to Laguna Honda.

viii. If discharge is not currently a viable option and is not included in the formal care plan, documents the reasons.
ix. Identifies differences of opinion among RCT members in regard to the resident’s discharge and encourages open discussions based upon professional assessments.

x. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

xi. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.

xii. Makes additional referrals as needed prior to discharge

xiii. Gives a copy of the discharge plan to the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

xiv. Completes the appropriate section of the Post-Discharge Plan of Care form (MR 705).

xv. Coordinates referral process to Diversion Community Integration Program (DCIP) for review prior to discharge.

d. Nurse

i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the plan of care.

iii. Arranges for discharge supplies as needed.

iv. Arranges pre-discharge pharmacy consultation for medication education.

v. Coordinates completion of the Post-Discharge Plan of Care form, including resident or surrogate signature, and provides a copy to the resident or surrogate.

e. Activity Therapist

i. Assesses and documents the resident’s pre-admission interests.

ii. Promotes maintenance/enhancement of IADLs through activities.

iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.
iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.

f. Other Disciplines / Services

In addition to the RCT responsibilities noted above

i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the Post-Discharge Plan of Care form.

ii. Occupational therapist / Physical therapist performs community reentry skills assessments as needed and arranges for durable medical equipment.

iii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborate with the social worker on enteral feeding supplies.

iv. Utilization management staff provides focused studies of the quality of discharge planning and documentation.

v. Vocational Rehabilitation meets with interested residents about vocational options, training, and community resources.

vi. Peer Mentors provide emotional and practical support to residents transitioning into the community.

6. Notification of Resident Regarding Discharge From Facility

a. The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or surrogate is entitled to written 30-day notification except under the following conditions:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

iii. Improvement in medical condition requiring a lower level of care.

iv. The health or safety of individuals in the facility is endangered.

v. Resident has resided in the facility less than 30 days.

b. Written notice (MR 707) to the resident or surrogate shall include:
i. Reasons for discharge.

ii. Date the discharge will occur.

iii. Discharge destination.

iv. Name, address, and phone number of the State ombudsman.

v. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

vi. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

vii. Resident’s right to appeal to the California State Department of Health Services.

viii. Resident’s right to request a seven-day bed hold.

c. Residents may choose to waive their notice period if they wish to be discharged prior to the conclusion of the notice period.

d. If the resident or SDM is opposed to discharge, s/he will be encouraged to discuss it with the RCT and ombudsman.

i. The social worker or nurse manager will alert the Medical Director, Chief Nursing Officer or designee, Director of Quality Management, and Executive Administrator (or their designee) prior to issuance of the written notification of discharge.

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

7. Involuntary Discharges

a. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. Legal counsel shall be consulted in circumstances when the resident and or SDM refuses to participate in discharge planning efforts (e.g. refuses to sign release of information forms or complete housing applications, etc.).
b. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with a minimum of two housing options that the RCT considers to be the best viable discharge option available in the community.

c. Refer to LHHPP File 20-05 Discharge Appeal Process when the resident verbalizes that s/he disagrees with the plan to be discharged to the community and refuses reasonable placement options.

8. Residents Leaving Against Medical Advice (AMA)

a. When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.

b. If the resident is conserved or does not understand the nature and consequences of a decision to leave Laguna Honda without permission, the physician will immediately attempt to contact the surrogate.

c. If leaving Laguna Honda would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.

d. If the consultant deems the resident a danger to self or others due to mental illness, he or she will initiate a psychiatric hold and transfer the resident to acute care.

e. The nurse or physician will present the form MR 804, “Request to Leave the Hospital Against Medical Advice” to the resident (or surrogate) in the presence of a witness.
   i. If the resident or surrogate refuses to sign, the nurse or physician will write on the form, “Resident refuses to sign.” Nurse/physician and witness will sign.

f. The nurse or physician will complete an Unusual Occurrence form.

g. When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.

DEFINITION:

1. ADLs and IADLs: Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:
2. Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
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<tbody>
<tr>
<td>Dressing</td>
<td>Shopping</td>
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<tr>
<td>Eating</td>
<td>Housework</td>
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<tr>
<td>Ambulating</td>
<td>Accounting/finances</td>
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<td>Toileting</td>
<td>Food preparation</td>
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<td>Hygiene</td>
<td>Transportation</td>
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3. Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).
ATTACHMENT:
Attachment A: Substance Abuse and Dual Diagnosis Treatment Placement for LHH Patients
Attachment B: LHH SATS Referral Protocol for Opiate Replacement Treatment

REFERENCE:
LHHPP 20-05 Discharge Appeal Process
LHHPP 20-06 Pass Policy
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Development and Implementation of an Interdisciplinary Resident Care Plan
NPP C1.0 Admission, Relocation and Discharge Procedures

Revised: 08/04/29, 09/10/27, 13/05/28, 13/09/24, 13/11/21 (Year/Month/Day)
Original adoption: 03/07/15
This is a protocol for coordinating assessment and placement for LHH patients requiring substance abuse and dual diagnosis treatment.

**LHH Substance Abuse Treatment Services (SATS):**

1. LHH SATS staff in conjunction with the Resident Care Team (RCT) will identify patients at LHH suitable for substance abuse and dual diagnosis residential treatment services.
2. LHH SATS staff will administer the Standard Fifth Edition Assessment Severity Index (ASI) “Lite,” and gather any additional pertinent clinical documentation e.g., the Admission H&P, Psychiatric and/or Neuropsychological Consultation Reports, and other information, in the form of a referral packet.
3. LHH SATS staff will review and obtain the resident signature on all necessary Behavioral Health Access Center (BHAC) Treatment Access Program (TAP) treatment consent forms.
4. For dual diagnosis residential treatment facilities, LHH SATS staff will complete an application and fax it to the Placement Team for authorization.
5. For non-dual diagnosis and direct referrals, in collaboration with LHH medical social workers, LHH SATS staff will present the identified patient’s substance abuse treatment service needs in the Diversion Community Integration Program (DCIP) meetings, and will give the referral packet to a TAP representative at the meeting. A recommendation and prioritization of the patient into the most appropriate level of care will be conducted by DCIP based on bed availability.
6. Should DCIP cease to exist as the forum for comprehensive discharge planning, LHH SATS staff will present the identified resident at the TAP morning rounds at 1380 Howard Street site, where a treatment recommendation and prioritization of the patient into the most appropriate level of care will be conducted based on bed availability.
7. LHH SATS staff will provide ongoing substance abuse treatment services (e.g. therapeutic groups, psychoeducational groups, individual counseling) to the identified patients while they are at LHH.
8. LHH SATS staff will continue to follow the patient at LHH until placement. LHH SATS staff will keep TAP case manager apprised of the emergence of any pertinent clinical issues related to change in functioning or daily care needs to ensure appropriate placement.
9. Once a placement site is identified, LHH SATS staff will escort the patient to an interview at the placement site.
10. If accepted for placement, an admission date with be set up by TAP and/or the receiving program. The LHH SATS staff will be responsible for coordinating the discharge with the patient’s LHH medical social worker.
11. For patients requiring opiate replacement treatment, LHH SATS staff will work with the patient’s medical social worker to make a referral to an appropriate clinic (see Attachment 2.)
12. LHH SATS staff will conduct follow-up visits as needed to the patient while he/she remains in treatment.

**Treatment Access Program (TAP)**

1. A TAP representative will attend the DCIP meetings regularly.
2. Once the LHH SATS staff has presented a case at DCIP, a TAP case manager will be assigned and designated as the TAP contact person for LHH SATS staff throughout the placement process. The TAP case manager will provide timely updates to LHH SATS until the patient is admitted into residential treatment.
3. The TAP case manager will provide LHH SATS staff with consultation regarding placement concerns or treatment alternatives should the patient have a change in clinical need.
4. TAP will provide ongoing general consultation to LHH SATS regarding other treatment modalities, (e.g., outpatient, 12-step, etc.) available at the community level.
Attachment B: LHH SATS Referral Protocol for Opiate Replacement Treatment

Updated: 9/19/2013

This is the protocol for referring a LHH patient who is on opiate replacement therapy (not for pain) to appropriate outpatient clinics for continuing treatment upon discharge. It is the responsibility of the patient’s medical social worker to inform LHH SATS staff about the patient’s need for opiate replacement treatment referral two weeks prior to the discharge date.

**LHH Substance Abuse Treatment Services (SATS):**

1. Upon receiving the notice from medical social worker, LHH SATS staff will verify with the primary physician that the identified patient is receiving opiate treatment for opiate dependence, not for pain.
2. LHH SATS staff will verify with the patient where he/she had received opiate replacement therapy prior to his/her hospitalization. If the therapy is new to the patient, LHH SATS staff will identify an appropriate clinic for the patient.
3. LHH SATS staff will ask the patient to sign a consent form to release information for an intake at the identified clinic.
4. LHH SATS staff will confirm the patient’s opiate dose per medical record.
5. LHH SATS staff will be responsible for completing and faxing the Methadone Confirmation, Community Referral Form, and a TB clearance to the identified clinic.
6. LHH SATS staff will schedule an intake at the identified clinic for the day after the patient’s scheduled discharge date.
7. LHH SATS staff will enter a note into the LCR specifying the date, time, location of the scheduled intake appointment, and notify the medical social worker of the information.
8. LHH SATS staff will provide copies of the above forms to the medical social worker.
9. For patients on buprenorphine, LHH SATS staff will contact the DPH Office Based Buprenorphine Induction Clinic (OBIC) for referral.

**LHH Medical Social Workers**

1. The medical social worker will notify LHH SATS staff about patients requiring opiate maintenance therapy at least two weeks prior to the discharge date.
2. The medical social worker will make sure that for BAART/Turk or BAART/Market Clinic, the patient has a California ID and a MediCal card.
3. The medical social worker will provide the patient with a list of his/her current medications and copies of the Methadone Confirmation, Community Referral Form, and TB clearance to present at the intake appointment at the identified clinic.
4. For patients on buprenorphine, the medical social worker will confirm that the patient is enrolled with a primary care provider (PCP) who has an X number, and notify the PCP that the patient is taking buprenorphine.
TRANSPORTING THE RESIDENT’S FILED MEDICAL RECORDS ON CAMPUS

POLICY:

1. Medical records are the property of Laguna Honda and original medical records must not leave the campus except by court order, subpoena or expressed authorization by the executive administrator or designee. Security of the medical record during transport within Laguna Honda campus is to be maintained.

2. The neighborhoods shall maintain a tracking system for when the medical record is transported off the unit and returned.

3. Refer to LHHPP24-08 for off campus appointments or activities.

PURPOSE:

The purpose of this policy is to safeguard the medical record (commonly known as the “chart”) during transport within Laguna Honda. (For off campus processes, refer to LHPP 24-08 Off Campus Appointments or Activities.)

PROCEDURE:

1. Medical records are transported to the outpatient clinic, radiology, and the rehabilitation department for resident appointments, unless the provider or designee specifies that the medical record is not needed. The chart must be handed to a staff person receiving the chart or placed inside the clinic office on the chart rack provided and must never be left on the reception table or counter unattended.

2. Medical records may also be transported

   a. for medical records processing, from neighborhoods or outpatient clinic to the Health Information Services (HIS) Department.
   b. for audits and reviews, from neighborhoods/HIS Department to departments conducting healthcare operations.

3. Laguna Honda staff, affiliating clinical or medical records students, and designated, trained volunteers are permitted to transport medical records.

4. Residents and family members are not to transport medical records.

5. Volunteers are designated for medical record transport by the department to which they are assigned based upon their willingness and ability to assume this role and the completion of HIPAA Privacy training by the Privacy Officer or designee.
6. Staff, affiliating students, and designated volunteers must participate in initial and annual training utilizing the DPH HIPAA clinician level training and sign and comply with the DPH User Confidentiality and Electronic Agreement Form. This form is available on the Laguna Honda Intranet.

7. A chart log will be maintained by nursing staff on the respective neighborhood.

8. Any part of the medical record that appears to be missing must be reported immediately to the Privacy Officer and/or Quality Management in order to expand the investigation process and comply with suspected privacy breach reporting requirements.

ATTACHMENT:
None

REFERENCE:
LHHPP 21-01 Medical Records Information: Confidentiality And Release
LHHPP 21-04 HIPAA Compliance
LHHPP 24-08 Off Campus Appointments Or Activities
DPH Privacy Policy – HIPAA Compliance
DPH User Confidentiality and Electronic Agreement Form

Revised: 13/01/29, 13/11/21.
Original adoption: 11/09/27
HAZARDOUS DRUGS MANAGEMENT

POLICIES:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.

2. The administration of intravenous hazardous drugs (HDs) shall be restricted to the Pavilion Mezzanine Acute (PMA) and Positive Care Units.

3. Clinical staff responsible for the ordering, dispensing, administering and monitoring of intravenous hazardous drugs shall be provided with training and demonstrate competency in hazardous drug administration.

PURPOSE:

1. To safely handle, administer, and dispose of Hazardous Drugs (HDs). This Policy has procedures relating to four areas of care:

   a. Prescribing and Transcribing Chemotherapy/Antineoplastic Drugs
   b. Preparing, Administering and Disposing of Hazardous Drugs (HDs)
   c. Exposure and Spill Management of Hazardous Drugs (HDs)
   d. Special Exposure Concerns

DEFINITION:

1. Antineoplastic Drug: Any drug that prevents the development, growth, or proliferation of malignant cells (anti-tumor).

2. Chemotherapy Agent: A chemical agent used to treat cancer.

3. Cytotoxic Drug: Any drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer (antineoplastics) and in some cases those drugs are used to treat other conditions (e.g. psoriasis, arthritis, transplant rejection). However, not all antineoplastics are cytotoxic nor are all cytotoxics used exclusively in the treatment of cancer.

4. Exposure: Cutaneous or mucosal contact with a hazardous agent.

5. Hazardous Drug (HD): Any drug which poses significant risk to a healthcare worker by virtue of its teratogenic, mutagenic, carcinogenic, reproductive toxicity potential, or which can cause serious organ or other toxic manifestation at low doses. Drug classes listed as HD include: antineoplastic agents, hormonal agents, immunosuppressants, some antiviral agents, some antibiotics and some biological response modifiers.
6. Hazardous Drug Waste includes Hospital Pharmacy listed Hazardous Drugs which include all chemotherapy agents, as well as the vials, ampoules, i.V. bottles, tubing, syringes, gloves, masks, absorbent pads, and other contaminated items used in the preparation, administration and handling of these materials. For contaminated gowns and linen see section D.

7. RCRA (Resource Conservation and Recovery Act) Hazardous Waste: EPA P-listed materials that are considered to be “acutely hazardous” if found in the waste stream (see Appendix B). Laguna Honda pharmacy identifies these items with “black dots”. Examples include nicotine and warfarin. These drugs require special waste disposal.

8. Vesicant: Any agent that has the potential of causing blistering or tissue necrosis if infiltrated/ extravasated.

PROCEDURE:

1. Procedure for Prescribing and Transcribing Chemotherapy/Antineoplastic Drugs (* Not including Hormonal agents used in cancer treatment)

a. Procedure for Prescribing Chemotherapy/Antineoplastic Drugs

i. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe Chemotherapy/Antineoplastic Drugs, whether used for cancer chemotherapy or immunosuppression, when cosigned by the ward physician.

ii. The attending physician may order these drugs in consultation with and cosigned by the clinical pharmacist.

iii. All orders for chemotherapy/antineoplastic drugs, including changes in dose or frequency, will be written on the Laguna Honda Antineoplastic/Cytotoxic Medication Order Form.

iv. Chemotherapy/antineoplastic IV infusions initiated at SFGHMC will be ordered by the attending physician without pharmacy dispensing. For example, CADD pump continuous infusion of fluorouracil.

b. Procedure for Transcribing Chemotherapy/Antineoplastic Drugs

i. A registered nurse and a second licensed staff member (MD, Pharmacist, RN, LVN) will review the completed Antineoplastic/ Cytotoxic Medication Order Form with a standard drug reference book prior to transcription to confirm the completeness and accuracy of the order.

• Pay particular attention to drug, dose, frequency, route, duration and any change from previous dose(s).
ii. Refer questions regarding the order to the prescribing physician or the clinical pharmacist for clarification prior to administration.

iii. Medications and related orders (e.g. hydration, antiemetic, antineoplastic, etc.) will be transcribed in the order of administration.

2. Preparing and Administering Hazardous Drugs (HDs)
   a. Oral/Enteral Hazardous Drugs (HDs): Handling and Administration
      
      i. Confirm resident’s identity and follow other standard medication administration policies and procedures including handwashing.

      ii. Apply appropriate personal protective equipment (PPE) given the likelihood of particular exposure
          - Wear nitrile gloves when handling HDs and associated administration equipment.
          - Gloves should be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated
          - Wear protective gown and eye protection if risk of spillage or splashing is possible.
          - If there is any risk of inhalation of particles, wear an N95 respirator. Dispose of used masks in a cytotoxic waste container.
          - Wear gown and gloves within immediate work area only.
          - Remove protective clothing (if applicable) and gloves in a way so that the contaminated surface is inside and then dispose in a cytotoxic waste container.

      iii. Never crush, cut or break medications labeled as “hazardous” or “chemotherapy” or if warning label on medication container advises same.

      iv. Avoid direct contact with the powder contained in capsules or tablets and skin, mucous membranes, or the respiratory tract. Avoid inhaling powder from the drug. Particles may aerosolize and travel into the lungs or mucous membranes

      v. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for
vi. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy. Instill 30 mls of water should be instilled before and after medication administration.

vii. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes into the cytotoxic waste container (yellow container).

b. Intravenous Administration of Hazardous Drugs (HDs)

i. Equipment for units administering Intravenous Hazardous Drugs (HDs)

- Cytotoxic Spill Kit (available from CSR).
- Cytotoxic waste containers (YELLOW) must be ordered and maintained on the Unit during the entire course of therapy. The regular size container is available from Central Supply (CSR). Large (32 Gal) containers are available from Environmental Services.
- Chemotherapy gown and gloves (nitrile) are required and are available from CSR.

ii. Handling and Administering Intravenous Hazardous Drugs (HDs)

- Follow standard safe medication administration practices.
- Before parenteral HD administration, a RN and second licensed staff member (MD, RPh, or RN) must double-check the order against drug reference book and check intravenous preparation against the order. Then, the RN and a second licensed staff member must initial in the designated box on the Medication Administration Record.
- Use personal protective equipment (PPE) including:
  - Chemotherapy gown and nitrile gloves when starting or discontinuing intravenous (I.V.), changing I.V. tubing or adding I.V. piggy-backs.
• Chemotherapy gowns are for one time use only; use a new gown for hanging medication and another new gown for taking down I.V. bag. Change gloves if punctured, torn or contaminated and every 30 minutes when working continuously with HDs.

• Used syringes, gowns, gloves, I.V. bags and tubing are placed in red biohazardous bag and disposed of in cytotoxic waste containers only.

• Wear gown and gloves within the immediate work area only. Remove and dispose of gloves when leaving resident’s bedside, even if returning shortly.

• Face shields or goggles are not usually needed, but caution is advised to avoid accidental splashes (e.g., when handling I.V. tubing changes or adding piggybacks above eye level).

• Start a new peripheral I.V. line for HD administration unless the resident has a central venous access device. If it is not possible to start a new I.V. line, the existing I.V. line may be used after determining patency by aspirating for blood return.

• Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.

• If tubing priming is necessary (because IV bag was not primed under laminar flow hood in pharmacy), keep below eye level and prime inside of plastic bag with gauze to avoid splash into eyes or mouth. Place used supplies into resealable (e.g., Ziploc) bag and dispose in the cytotoxic waste container.

• All continuous infusions must be delivered via an infusion pump.

• After a HD has been administered, all used syringes, tubing and other equipment including absorbent pad to prevent droplet contamination, are to be placed in red biohazard bag and disposed of in cytotoxic drum.

• When resident returns with continuous ambulatory infusion of hazardous medication initiated and dispensed at another approved health care facility, the procedures will be modified accordingly to insure safety and appropriate monitoring.

c. Subcutaneous Hazardous Drugs (HDs): Handling and Administration

i. Confirm resident’s identity and follow other safe medication administration policies and procedures including handwashing.
ii. **Apply appropriate personal protective equipment (PPE) given the likelihood of particular exposure**

- Wear nitrile gloves when handling HDs and associated administration equipment.
- Gloves should be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated.
- Wear protective gown and eye protection if risk of spillage or splashing is possible.
- Wear gown and gloves within immediate work area only.
- Remove protective clothing (if applicable) and gloves in a way so that the contaminated surface is inside and then dispose in a cytotoxic waste container.
- Obtain spill kit

iii. **Pharmacy will dispense the medication in the syringe for administration.**

d. **Disposal of Hazardous Drug Waste**

i. All antineoplastic drugs and Hazardous Drugs (HDs) that have been given to residents and contain more than residue (i.e. greater than 3% of the original volume) shall be disposed of in a cytotoxic waste container (yellow container).

ii. Hazardous Drug Waste that only contain residue in the dispensing container shall be disposed of in a pharmaceutical waste container (white and blue container).

iii. Any contaminated materials used in the preparation and administration of HDs, such as gloves, gowns, syringes and vials should also be disposed in a cytotoxic waste container.

iv. Unused, unopened or expired drugs, including RCRA hazardous waste (“black dot”) should be returned to the pharmacy for disposal.

- Do not pour hazardous drugs/solutions down drains or into toilets.
- Bag all contaminated I.V. equipment and supplies in a red biohazardous bag and then place it in the yellow container marked “Cytotoxic Waste”.
• Place leftover hazardous drugs/solutions in a large resealable plastic bag (e.g., Ziploc). Seal and dispose in cytotoxic waste container.

• Obtain a new cytotoxic waste container from Environmental Services when the current container reaches ¾ full or 90 days from first use or if malodorous, whichever comes first. Contact Environmental Services for removal and replacement of cytotoxic waste container.

• Environmental Services will label containers to note when they should be replaced and will pick up and replace the cytotoxic waste container on Pharmacy, Positive Care Units or any other Units upon notification.

• Use uncontaminated gloves to handle cytotoxic waste containers.

• If exposure involves a resident, provide immediate first aid as outlined below and immediately notify the physician and nursing supervisor. Complete a Confidential Report of Unusual Occurrence.

e. Handling and Disposal of Body Fluids From Residents Who Have Received Chemotherapy/Antineoplastic Drugs* Within the Previous 48 Hours (* Not including Hormonal agents used in cancer treatment)

Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen). For 48 hours post administration of antineoplastic medications following these specific guidelines:

i. Use nitrile gloves and gown when handling body fluids, particularly urine. A face shield shall be worn if splashing is possible.

ii. Discard disposable items contaminated with body fluids of patients who have received antineoplastic drugs in the previous 48 hours into a large red biohazard plastic bag and then dispose into the designated cytotoxic waste container.

• These items include diapers, urinals, bedpans, measuring devices, Foley catheters, drainage bags, and body fluids and fecal waste themselves.

iii. Potentially contaminated linen shall not be sent to Laundry.

iv. Linen contaminated with chemotherapy/antineoplastic drugs or excreta from patients who have received chemotherapy/antineoplastic drugs in the past 48 hours is a potential source of exposure to employees.

• Linen that is grossly contaminated with antineoplastic drugs or excreta from patients who have received chemotherapy/antineoplastic drugs in
the past 48 hours shall be placed in a red biohazard bag and then disposed of in a large yellow cytotoxic waste container.

- Linens used by patients who have received chemotherapy/antineoplastic drugs in the past 48 hours, which are not contaminated with body fluids shall be handled as other linen.
- Laundry personnel shall wear latex gloves and gowns while handling linens.

f. Staff laundering Practices:

i. Staff laundering residents’ potentially contaminated personal clothing within 48 hrs of receiving chemotherapy/antineoplastic medications will wear gloves AND gowns (double gloving is not required unless prolonged contact with highly wet/moist contaminated clothing likely). If splashing is possible, face shield should be used.

ii. Contaminated personal clothing will be:

- Washed separately from other residents if resident is incontinent.
- Placed in an impervious bag or a yellow cytotoxic waste drum (reserved for this purpose) for transport to washing machine.
- Sent through 2 cycles of washing (once a pre-wash, and a 2nd wash)

iii. Non-contaminated personal clothing will be handled as standard laundry procedure.

3. Exposure and Spill Management of Hazardous Drugs (HDs)

a. Exposure Management

i. Immediately remove the contaminated PPE and dispose in the cytotoxic waste container.

ii. Skin or mucous membrane contact: wash contact area thoroughly with soap and water. Avoid iodine preparations or chlorhexidine.

iii. Eye exposure: immediately flood affected eye with a gentle stream of water for at least 15 minutes with tap water or a 500-1000 ml bag of 0.9% sodium chloride or commercially available eye wash. Make sure the eye is open and the individual blinks and rotates eye in all directions.
iv. Needle stick or sharp exposure: Immediately rinse any sharps injury with soap and water. Report the exposure to the Needle stick hotline for expert assessment and advise regarding immediate treatment.

v. Obtaining medical attention immediately.

vi. Complete a “Supervisors Report of Injury” for exposed staff. Complete a Confidential Report of Unusual Occurrence for residents or other exposed individuals.

b. Spill Management

i. Spills are contained by the first competent staff person on the scene using the Chemotherapy/Cytotoxic Drug Spill kit maintained on Pavilion Mezzanine Acute (PMA), Positive Care Unit, Pharmacy, Supplemental Drug Room and CSR.

ii. Small spills of 5 ml or less or dropped pills may be wiped up with absorbent gauze (4x4) using gloved hands. Place in a resealable plastic bag (e.g., Ziplock) and discard in the cytotoxic waste container.

iii. For spills greater than 5 ml, use the Spill Kit.

- Caution bystanders to avoid the spill area to not disburse area of exposure and immediately obtain the spill kit from the treatment room.

- Open the kit. Use chemo spill caution sign to mark spill area.

- Apply personal protective equipment from the kit. If risk of aerosolization of powder medication, put on N95 respirator mask.

- Place materials to absorb cytotoxic materials in a “V” position on the outer perimeter of spill to prevent spread.

- Lightly place absorbent towels over spill, being careful not to touch the spill.

- Pick up saturated towels and spill pillows and place in red hazardous bag from the kit. Use disposable scoop and brush as needed to pick up debris.

- Remove mask, goggles, gown and inner gloves and dispose of in a large chemo waste bag and dispose the bag in the cytotoxic waste container.
iv. Special **Reproductive Health** Exposure Concerns

- Reproductive Hazards - Some studies have shown increased risks of miscarriage or of giving birth to malformed infants for persons occupationally exposed to certain HDs. The degree of risk for employees who are pregnant, or who are actively trying to conceive a child (female or male personnel) is uncertain at the present time.

- Personnel Breast-Feeding Infants - No data is available as to whether these persons are at increased risk

- Staff Medical Surveillance - Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, should not administer cytotoxic or hormonal agents labeled/classified as Hazardous Drugs.

Staff who fit into the above categories shall inform their immediate supervisor for work reassignment.

**ATTACHMENT:**

Appendix A Antineoplastic/Cytotoxic Medication Order Form MR153 (11/02)
Appendix B RCRA Hazardous Waste (EPA P-listed materials or Laguna Honda “black dot” drugs) (07/08)

**REFERENCE:**


Environmental Health and Safety Office: OUHSC Hazardous Drug Procedures;

CDC NIOSH (National Institute for Occupational Safety and Health). 2004- 165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings

U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; [www.osha.gov](http://www.osha.gov)


CROSS REFERENCE TO NURSING POLICIES AND PROCEDURES:
NPP J 1.0 Medication Administration
NPP J 6.0 Intravenous Infusion

CROSS REFERENCE TO PHARMACY POLICIES AND PROCEDURES:
PPP 07.00 Preparation, Handling, and Disposal of Hazardous Drugs section of Sterile Compounding Policy

CROSS REFERENCES TO ENVIRONMENTAL SERVICES POLICIES AND PROCEDURES:
ESPP

CROSS REFERENCES TO LAGUNA HONDA HEALTH AND SAFETY PROGRAM:
CHN/Laguna Honda Medical Waste Management Plan
Respiratory Protections

Revised: **13/11/21** (Year/Month/Day)
Original Adoption: 08/09/30
Replaces LHHPP 70-02 Cytotoxic Agents (Chemotherapy) (rev. 03/05/08)
Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)
Appendix A:

Antineoplastic/Cytotoxic Medication

Order Form

- All oral and parenteral antineoplastic/cytotoxic medication MUST be ordered on this form, including all changes in dose or frequency.
- All information marked with an asterisk (*) must be completed before the medication is dispensed.
- Orders for antineoplastic/cytotoxic agents, whether used for chemotherapy or immunosuppression, must be written by the consulting specialist (oncologist, rheumatologist, dermatologist) and cosigned by the ward physician, or ward physician with consultation from the clinical pharmacist.
- Orders for dosages of methotrexate exceeding 15mg per week must be reviewed by a clinic pharmacist.

Patient Clinical Information

Diagnosis*: _________________________________________________________

Allergy*: ______________________________________________________________________________________

Height: ___________ (ft/in) Weight (Corrected weight if obese)*: ____________ (lb)

Antineoplastic/Cytotoxic Start Date* and Time:

Special Instructions (If pre-hydration, post-hydration and premedication are needed, please specify):

Drug Name*  Dose*  Route*  Frequency*  Duration*

(Solution, volume and infusion rate of parenteral antineoplastic/cytotoxic MUST be specified):

Routine Laboratory monitoring (check all that apply)*  Frequency (check all that apply)*

CBC w/ differential and platelet counts  □ Baseline (today)  □ Q___________

Liver function tests (Albumin, TBL, (total bilirubin); DBIL (direct bilirubin), ALKP, AST, ALT  □ Baseline (today)  □ Q___________

Metabolic Panel (Electrolyte, BUN/Scr, Glucose)  □ Baseline (today)  □ Q___________

Other test (specify):  □ Baseline (today)  □ Q___________

SIGNATURES

Ordering MD Names: _______________________________  MD Signature: _______________________________

MD Pager: ____________ Date/Time: ____________

Unit MD Signature: _______________________________

(Unit MD Signature is required if order is written by a consulting MD)

PAGER: ____________ Date/Time: ____________

Clinical Pharmacist Signature: _______________________________

(Rx Pager: ____________ Date/Time: ____________

(Clinical Pharmacist Signature is required if order needs to be reviewed as indicated above)

Transcriber Signature: _______________________________

Date/Time: ____________

RN Signature: _______________________________

Date/Time: ____________

Laguna Honda Hospital-wide Policies and Procedures
Appendix B:

**RCRA** (Resource Conservation and Recovery Act)
(P-LIST) HAZARDOUS WASTE

- Nicotine patches, gum, etc. (un-used)
- Warfarin/Coumadin (un-used)

Epinephrine syringes & vials, used nicotine patches and gum, and soufflé cups for warfarin that are not overly contaminated are NOT considered hazardous waste. Medicinal nitroglycerin is not explosive and is NOT considered hazardous waste. These items should be disposed as pharmaceutical waste or as sharps if they have needles.
STANDARD PRECAUTIONS

POLICY:

1. Clinical staff will use Standard Precautions (hand hygiene, use of personal protective equipment and environmental controls) in the care of all residents to reduce the risk of transmission of potentially pathologic microorganisms.
2. Standard Precautions apply to all body fluids (including blood), all secretions and excretions, all non-intact skin (including rashes), and to all mucous membranes.

PURPOSE:

To interrupt the spread of infection by all routes likely to be encountered in the health-care setting.

BACKGROUND INFORMATION:

Standard Precautions (SP) is an infection prevention system has been implemented at LHH. Standard Precautions are designed to prevent exposure to all potentially infectious body substances and are NOT based on specific resident diagnoses. The epidemiologic foundation for the use of SP is that the sources for many health care associated infections are microorganisms from colonized body sites of a resident in which infection is neither diagnosed nor suspected.

No special signs or alerts are necessary for implementation of Standard Precautions.

Standard Precautions, when practiced consistently, will reduce the risk of transmission from direct or indirect contact with infectious materials.
   a. Direct-contact transmission involves “touch” contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person.
   b. Indirect-contact transmission involves contact of a susceptible host with a contaminated surface or inanimate object.

Enhanced Standard Precautions (ESP) integrates and consolidates the CDC recommendations for Standard Precautions with many of the recommendations for Transmission-based Precautions and Intensified Interventions. (See appendix for full report from California Department of Public Health. [http://www.cdph.ca.gov/portal/server.pt?l=10263]"

PROCEDURE:

1. HAND HYGIENE AND PERSONAL PROTECTIVE EQUIPMENT (PPE)
Policy Number: C2 Standard Precautions
Revised November 21, 2013

Laguna Honda Hospital-wide Policies and Procedures
Page 2 of 5

a. **Hand hygiene**: Hands are to be washed with soap and water or cleaned with alcohol-based rub after contact with blood, body fluids, excretions, secretions, non-intact skin, mucous membranes, or potentially contaminated physical items.
   i. Hands are to be cleaned immediately before and after the use of gloves and between resident contacts, and between tasks and procedures on the same resident to prevent cross-contamination of different body sites (e.g., after perianal care, oral care, respiratory care procedures, or after care of any infected sites).
   ii. The use of gloves is never a substitute for meticulous hand hygiene.

b. **Gloves**: Clean gloves are to be worn when touching blood, body fluids, excretions, secretions, and contaminated items.
   i. Clean gloves must be put on just prior to touching mucous membranes or non-intact skin (e.g., prior to eye procedures or wound care).
   ii. Gloves must be worn whenever using a “sharp” (e.g., during injections or phlebotomy). Although gloves will not prevent needle sticks or other percutaneous exposures, a sharps injury which occurs through a glove may result in a reduced amount of potentially infectious fluid being transmitted.
   iii. Gloves are to be changed between tasks and procedures on the same resident, after contact with material that may contain a high concentration of microorganisms (e.g., after perianal care or respiratory care procedures, or after care of any infected sites).
   iv. Gloves are to be removed promptly after use, before touching any non-contaminated items or surfaces, and before going to another resident.
   v. Hands are to be cleaned immediately before and after glove use to avoid transfer of microorganisms.

c. **Mask/eye protection**: A mask with eye protection or a face shield are to be worn to protect mucous membranes of the eyes, nose and mouth during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions.
   i. Examples include: emptying drainage bags or suction canisters, passing nasogastric tubes, wound irrigation, intubations, and “open” system suction procedures, such as deep tracheal suctioning, and ANY other procedures health care workers anticipate may place them at risk for splash or splatter of body fluids.
d. **Plastic Aprons/Disposable Gowns**: Plastic aprons are to be worn to protect skin and to prevent soiling of clothing during procedures likely to generate splashes or splatter of blood or other body fluids.

   i. Examples include: when turning residents with large rashes or wounds, during irrigation procedures, and any time a potential splash or splatter may be anticipated. In addition, disposable gowns are available if greater protection is needed.

2. **ENVIRONMENTAL CONTROLS**

   a. **Resident care equipment**: Used resident-care equipment soiled with blood or other body fluids is to be handled in a manner to prevent skin or mucous membrane exposures, and to prevent contamination of clothing or other objects.

      i. Reusable equipment that is visibly contaminated is not to be used for the care of another resident until it has been cleaned and disinfected appropriately.

      ii. Single use items are to be discarded immediately after use.

      iii. All other resident care equipment is to be designated for cleaning and disinfection on a regularly scheduled basis.

   b. **Environmental controls**: Written cleaning schedules for beds, bed rails, bedside equipment, and other frequently-touched surfaces in the resident care rooms are established by Nursing and by Environmental Services/Housekeeping.

      i. Cleaning schedules are to be based on commonly accepted guidelines and community standards.

      ii. Cleaning and disinfection protocols are usually department-specific; refer to department-specific policies.

      iii. Some equipment has special disinfection guidelines, which are to be carefully followed.

   c. **Linen**: Used linen may be soiled with blood or other body fluids. Therefore all linen is handled, transported, and processed in a manner to prevent skin or mucous membrane exposures, and to prevent contamination of clothing or other objects.

      i. **Impermeable**, fluid-resistant bags are to be used for the transport of all linen from resident care areas.

   d. **Resident Placement**: When a resident is newly admitted or relocated to a new bed, care is to be used to avoid transfer of microorganisms between residents.
i. A resident who does not, or cannot be expected to maintain appropriate hygiene and who contaminates the environment is to be placed in a private room, if possible.

ii. If no private room is available, a resident who cannot maintain hygiene is only to be placed near people at low risk for acquiring infections. Low-risk people are ambulatory, well-nourished, free of open wounds and invasive devices, and have unimpaired immune systems.

e. Occupational Health/ Blood borne pathogens:
   i. Health care workers are to take care to prevent injuries at all times and specifically:
      - When using needles, scalpels, and other sharp instruments or devices
      - When handling sharp instruments after procedures
      - When cleaning and reprocessing used instruments
      - When disposing of used needles and other sharps.
   ii. Safety devices are used when appropriate.
   iii. All health care workers using needle safety devices are to be educated regarding proper use on orientation and when a new device is introduced.
   iv. Safety devices are to be activated immediately after use.
   v. LHH strongly discourages the recapping of needles and in general, needles are not to be recapped.
   vi. In the rare instance when recapping cannot be avoided, needles are NEVER to be recapped using both hands. Needle handling must never include any technique that directs the point of the needle toward any part of the body.
   vii. If needles must be recapped, a one-handed “scoop” technique is to be used, or a mechanical device is to be used to hold the needle sheath.
   viii. Used needles are not to be removed from disposable syringes prior to disposal. Needles are not to be bent, broken, or otherwise manipulated by hand.
   ix. Used disposable needles and syringes, scalpel blades, and other sharp items are to be disposed of immediately into the plastic, puncture-resistant “Sharps” containers, which are located close to the area in which the items are to be used. Sharps containers are to be replaced when ¾ full.
   x. Careful selection of personal protective equipment (e.g., masks with eye shields) is to be used to prevent exposure to blood and other body fluids. Mouthpieces, resuscitation bags, and other ventilation devices are to be maintained in areas where the need for resuscitation is predictable. Direct mouth-to-mouth resuscitation is to be avoided.

ATTACHMENT:
None
REFERENCE:

APIC Text 3rd Edition 2009

Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Committee (HICPAC), 2007. Guideline for Isolation Precautions in Hospitals.


Revised: 2013/11/21
Original adoption: 2005/11
QUARTERLY PROGRESS NOTE FORMAT

POLICY:

Every three months, a quarterly progress note is required for each resident.

PURPOSE:

The note demonstrates a plan has created and monitoring is occurring.

PROCEDURE:

1. Progress Notes are written in the Integrated Progress Notes section of the medical record.

2. The progress notes are written on are before the due date indicated on the RAI schedule for quarterly assessments.

3. Activity Therapy progress notes are written in the next available space within the Integrated Progress Notes section.

4. Notes are dated, timed, and entitled “Activity Therapy Progress Note.” Progress notes are written in a narrative format and include the following:
   a. A statement of the Activity Therapy plan of care or goals for the past three months.
   b. A description of the resident’s participation in activities including types of activities and behaviors during activities. Note any changes to activity participation and precipitating factors.
   c. Changes in functional abilities.
   d. Current problems or needs that are limiting the resident’s participation in activities or having a negative impact on the resident’s functional abilities and life in general.
   e. An indication of the general direction of Activity Therapy interventions for the coming quarter.

5. Activity Therapy staff write progress notes more frequently to document something of significance related to the resident’s plan of care.

6. The note may document something positive such as an accomplishment.

7. The note may document an issue or situation that is impacting or may have impact on the residents overall plan of care.

8. This type of Activity Therapy Progress Note should not to be confused with a Focused Progress Note which documents a significant event, usually negative, and usually requires review and/or revision to the resident care plan.

9. The progress note is signed by the Therapist.

REFERENCE:
None

ATTACHMENT:
None

Revised: 12/12/2012, 11/21/2013
CLEANING OF EXAMINATION ROOMS

POLICY:

Outpatient Clinic examination rooms are cleaned and disinfected according to LHH Infection Control Policy G3, "Cleaning of Examination Rooms."

PURPOSE:

Outpatient Clinic examination rooms are maintained in a clean condition to prevent the transmission of disease.

PROCEDURE:

Refer to LHH Infection Control Policy G3, "Cleaning of Examination Rooms."

Reference:
LHH Infection Control Policy G3, "Cleaning of Examination Rooms."

Most recent review: 10/10, 13/08/02
Revised: 13/11/21
Original Adoption: 09/02
Approved: 09/02
NON-CRITICAL RESIDENT CARE EQUIPMENT

POLICY:

Non-critical resident care equipment in the Outpatient Clinics is cleaned and disinfected according to LHH Infection Control Policy G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment" and accepted standards of practice.

PURPOSE:

Contamination of non-critical patient care equipment is prevented by routine cleaning and disinfection.

DEFINITIONS

Non-critical resident care equipment included items that come in contact with intact skin, but not mucous membranes. Intact skin is an effective barrier and sterility is not critical.

Non-critical equipment includes but not limited to:
- Blood pressure cuffs
- Stethoscopes
- IV stand
- Suction machine
- Dopplers
- Oximeters
- Stretchers and wheelchairs

PROCEDURE:

1. DISINFECTANT CLEANER

A hospital-approved disinfectant cleaner, containing both disinfectant (phenol-based or quaternary ammonium based) and detergent is used for the purpose of cleaning and disinfecting non-critical patient care equipment. Refer to LHH Infection Control Policy G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment".

2. DESIGNATION OF RESPONSIBILITY/STANDARDS OF PRACTICE

Clinic staff will clean and disinfect equipment between resident use. Refer to LHH Infection Control Policy G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment".

REFERENCE:

LHH Infection Control Policy G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment".

Most recent review: 10/2010, 13/08/02
Revised: 13/11/21
Original Adoption: 02/2009
Approved:
CLEANING OF MEDICAL INSTRUMENTS PRIOR TO DISINFECTION OR STERILIZATION

POLICY:

Reusable medical instruments are cleaned prior to disinfection or sterilization consistent with LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments".

PURPOSE:

Reusable instruments may serve as a vehicle in the transmission of infections if they are not properly processed. To ensure the final anti-microbial process (i.e., sterilization, high level disinfection, etc.) is effective, prior disassembly and cleaning is required.

PROCEDURE:

1. Use of Personal Protective Equipment and Attire
   A. Gloves:
      Vinyl or latex gloves are worn when hand-washing delicate microsurgical instruments.
      Thicker, more durable gloves are worn for handling full trays of instruments, other heavy items or sharps.
      The cuff of the gloves shall be long enough to prevent water from coming over the wrist and into the glove.
   B. Gowns:
      Long sleeved, fluid-resistant cover gowns are worn. Gloves are pulled up over the gown cuff.
   C. Masks and Eye Protection:
      To prevent mucous membranes from potential splashes, sprays, or aerosols created during the processing, a fluid resistant mask and eye protection must be worn.
   D. Feet and Leg Protection:
      Rubber or plastic boots or disposable shoe cover/legging combinations are worn when processing items where large amounts of fluid will be involved.
   E. Hair
      Hair must be covered with a cap.
2. **Soaking (Pre-Cleaning)**

   Immediately after use, medical instruments are immersed in enzymatic detergent and soaked until cleaning. Soaking of instruments is required to prevent drying of blood, body fluids or other organic materials on instruments.

   Soaking is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations. Tepid water is used to prevent coagulation of protein materials.

   When soaked items are transferred from one location to another, all liquid is removed prior to transfer. Containers must be either a plastic or rubber bin with a lid or a solid bottomed rigid sterilization container system with the lid in place.

3. **Cleaning**

   Cleaning is the single most important step in making a medical instrument ready for reuse. Without adequate cleaning, disinfection and sterilization processes are ineffective.

   Cleaning can be done **manually or mechanically** (by machines). Whenever possible, cleaning is done mechanically.

   Instruments that require disassembly must be disassembled prior to cleaning to ensure exposure of all surfaces to the cleaning process.

   Cleaning is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations.

   **A. Manual Cleaning:**

   The sink used for cleaning instruments is separate from those used for hand-washing or surgical scrub.

   Instruments are not cleaned under *running* water, as this will create aerosols. Immersible instruments are cleaned under water. Items that cannot be immersed are cleaned in a manner that does not produce aerosols.

   Brushes and other cleaning implements are used to facilitate in the cleaning process. Brushes and other cleaning implements are disinfected or sterilized daily.

   **B. Mechanical Cleaning:**

   In the Outpatient Clinics an ultrasonic cleaner is used for mechanical cleaning. Refer to Appendix A: Operation of the Mettler Electronics Cavitator Ultrasonic Cleaner Model ME 5.5

   **C. Rinsing and Drying:**

   After cleaning, instruments are thoroughly rinsed with potable water and manually dried with a cloth or allowed to air dry.
Appendix A: Operation of the Mettler Electronics Cavitator Ultrasonic Cleaner Model ME 5.5

1. Fill the tank with enough water and appropriately diluted detergent to cover the platform and the instruments to be cleaned. A facility approved high sudsing, neutral pH detergent is used.

2. Plug the unit into a grounded AC outlet.

3. Turn the timer/switch to 15 minutes. Cleaning will start immediately as evidence by a "hissing" sound from the tank. The "hissing" sound indicated vapor-phase cavitation, the most efficient type of cavitation.

4. After the designated time has elapsed, the unit will automatically turn off.

5. Remove the instruments for rinsing and drying.

6. Drain the tank.

7. Unplug the unit.

Reference:
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments".

Most recent review: 10/10. 13/08/02
Revised: 13/11/21
Original adoption: 00/02
Approved:
HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:

High-level chemical disinfection is performed by trained and qualified Clinic Staff according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

PURPOSE:

High-level chemical disinfection is a process used for the disinfection of semi-critical resident care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores.

PROCEDURE:

1. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments" and to LHH Outpatient Clinic Policy C3 "Cleaning of Medical Instruments Prior to Disinfection and Sterilization".

2. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.

3. Hospital approved high-level disinfectants must be used.

   Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

4. Refer to Appendix A for Specific instructions on the use of Cidexplus® Solution (glutaraldehyde 3.4%) for high-level disinfection.

5. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and Legionella.

Reference:
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"

Revised: 13/11/21
Original adoption: 09/02
Appendix A: Use of Cidexplus® Solution (glutaraldehyde 3.4%) for High-Level Chemical Disinfection

For Complete information on use refer to Cidexplus® Product information

1. Material Compatibility

For compatibility of device materials with Cidexplus® refer to device manufacturer’s recommendations and Cidexplus® Product information.

2. Cleaning Agent Compatibility

Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus® Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus® Solution.

3. Safety

Caution: Contains Glutaraldehyde
- Harmful by inhalation and if swallowed
- Irritating to respiratory system and skin
- Risk of serious damage to eyes
- May cause sensitization by inhalation and skin contact

Precautions
- Wear suitable protective clothing, gloves and eye/face protection
- Use only in well-ventilated areas
- Avoid contamination of food
- Avoid release to the environment

First-Aid Measures
- Refer to Cidexplus® Produce Information

4. Directions for Use

Activation
a. Activate the Cidexplus® Solution by adding the entire contents of the Activator Vial, which is attached to the Cidexplus® Solution container. Shake well. Activated solution immediately changes color to green indication that the activator has been added to the solution.
b. Record the date of activation (mixing date) and expiration date on the container label in the space provided add the initials of the individual who performed the mixing.
c. Test the activated solution with Cidexplus® Solution Test Strips prior to each use. The minimum effective concentration (MEC) of glutaraldehyde is 2.1%. Cidexplus® Solution Test Strips monitor the MEC of 2.1%

5. Cleaning
Feces, mucous, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus® Solution.

Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus® Solution.

Clean and rinse lumens of hollow instruments before filling with Cidexplus® Solution.

6. Usage
   a. Test the activated solution with Solution Test Strips prior to each use.
   b. Immerse cleaned and rough dried medical devices completely in the Cidexplus® Solution, filling all lumens.
   c. Leave medical devices completely immersed for at least 20 minutes at room temperature for High-Level Disinfection.
   d. Rinse with sterile water
   e. Used gluteraldehyde solution is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal

Most recent review: 10/10
Revised: 13/08/02
Original adoption: 09/02
CLINIC STAFF LICENSURE & CERTIFICATION

POLICY:
Outpatient Clinic Staff will be qualified by training, experience and certification for the services they perform in providing care to the LHH residents and Community clients.

PURPOSE:
To ensure that Clinic staff maintain current licenses and certifications to perform their job duties.

PROCEDURE:
The following employee classes are required to maintain certificates and licenses:

1. Registered Nurses (RN) are required to have a current license issued by the State of California, Board of Nursing and a current BLS certification.
2. Licensed Vocational Nurses (LVN) are required to have a current license issued by the State of California, Board of Nursing and a current BLS certification.
3. Medical Evaluation Assistants (MEA) are required to have a current license issued by the State of California, Department of Public Health, CPT1 and a current BLS certification.

Revised: 13/11/21
SIMPLE SURGICAL PROCEDURES IN OUTPATIENT CLINIC

POLICY:

It is the policy of LHH that patients be given adequate information about the risks, benefits and alternatives for any operation, and special diagnostic or therapeutic procedure which involves significant risk of bodily harm.

The physician performing the procedure in the outpatient clinic setting is responsible for ensuring that adequate disclosure is made and informed consent is obtained prior to instituting such a treatment. (please see LHH Medical Staff P&P “Patient's Consent for Treatment and Operation”)

DEFINITION:
Surgery is a procedure that structurally alters the human body. Any procedure considered invasive as defined in the State Operations Manual requires consent and a pre-operative History and Physical.

Simple surgical procedures are those procedures that require only an informed consent and not a pre-operative assessment prior to performing the procedure which includes but not limited to injection into a joint, bursae, tendon sheath or soft tissue; and injection of a local anesthetic. The procedures requiring a local anesthesia injection shall include but are not limited to tissue biopsy, fine needle aspirations, suturing of tissue, incision and drainage of wounds., nail avulsion, root canal, teeth extraction, and fillings. Any procedure that does not require injection of a local anesthetic does not need an informed consent or a pre-operative history and physical.

PURPOSE:

The purpose is to provide on-site simple surgical procedures to assist the Medical Staff of LHH in the care of residents.

PROCEDURE
The physician performing the procedure will obtain the informed consent as outlined in LHH Medical Staff P&P "Patient's Consent for Treatment and Operation.

Follow up of patients will be provided per physician recommendations until deemed to have healed or received adequate treatment and follow-up by the consultant MD.

Surgeries or procedures that require the patient to receive services outside of LHH will follow the policies and procedures of the facility.

REFERENCES:
LHH Medical Staff P&P Patient's Consent for Treatment and Operation

Revised: 13/11/21
ARTERIAL BLOOD GAS COLLECTION: POINT OF CARE TESTING

POLICY:

1. Arterial puncture may be performed by any physician or by the respiratory care practitioner or specially trained nurses.

PURPOSE:

1. To procure arterial blood for analysis of PH, PCO₂ and PO₂. O₂ saturation is obtained externally.

I. ARTERIAL BLOOD GASES

A. Principle
   1. Type of Reaction:
      The OPTI analyzer is a microprocessor-based instrument measuring optical fluorescence. Fluorescent optodes (optical electrodes) measure the intensity of light emitted from fluorescent dyes exposed to specific analytes. Emitted light is distinguished from excitation light by optical filters; excitation light energy is kept constant. Light emitted after specimen contact is thus directly related to the concentration of an analyte. Concentration of an analyte is determined by calculating the fluorescence difference measured at a known calibration point with that measured for the analyte of unknown concentration.

      A disposable, single-use cassette contains all the elements needed for calibration, sample measurement and waste containment. Each cassette is calibrated individually, with the calibration information encoded in the “bar code” present on the cassette packaging. After “swiping” the cassette package through the bar code reader contained on the instrument, the cassette is placed into the measurement chamber. The analyzer warms the cassette to 37.0 ±0.1 °C and passes a precision calibration gas mixture across the optode sensors to verify the calibration of the PCO₂ and PO₂ sensors. The pH channels are calibrated with a precision buffer solution contained within the cassette. When cassette calibration is verified, the analyzer aspirates the blood sample into the cassette and across the optode sensors. Fluorescence emission is measured following equilibration with the blood sample.

      During each analyte measurement, light originating from lamps in the analyzer is passed through optical filters. Photons of a specific color are transmitted to the sensors, resulting in fluorescence emission. The intensity of this emitted light is dependent on the partial pressure of oxygen (PO₂), carbon dioxide (PCO₂), and hydrogen ion concentration (pH). Light emitted by the fluorescent sensors, after passing through lenses and additional optical components, is measured by the analyzer. A filter is used to isolate specific colors of interest for measurement by a light detector. The output signal of the detectors is converted by a microprocessor to a numeric readout in conventional units of measure and displayed on the front of the device.

   2. Clinical Reasons for Tests:
      A. pH: The pH value is an indicator of the balance between the buffer (blood), renal (kidney) and respiratory (lung) systems, one of the most tightly controlled parameters in the body. An increase in blood, serum or plasma pH (alkalemia) may be due to increased plasma bicarbonate, or a feature of respiratory alkalosis due to an increased elimination of CO₂ due to hyperventilation. A decreased pH value (acidemia) in blood, serum or plasma may occur due to an increased formation of organic acids, an increased excretion of H ions in certain
renal disorders, and increased acid intake such as in salicylate poisoning or loss of alkaline body fluids. Respiratory acidosis is the result of a decreased alveolar ventilation and may be acute; as the result of pulmonary edema, airway obstruction or medication, or maybe be chronic; as the result of obstructive or restrictive respiratory diseases.

B. $PCO_2$: The $PCO_2$ value of arterial blood is used to assess how well the body eliminates carbon dioxide, a by-product of metabolism. A $PCO_2$ value below the normal range is termed respiratory alkalosis and indicates hypocapnia, a condition caused by increased alveolar ventilation (e.g., hyperventilation). An arterial $PCO_2$ above the normal ranges is termed respiratory acidosis and indicates hypercapnia, a sign of ventilatory hypoventilation and failure, resulting from cardiac arrest, chronic obstructive lung disease, drug overdose, or chronic metabolic acid-base disturbances.

C. $PO_2$: The $PO_2$ value of arterial blood is used to assess how well the body is able to absorb oxygen in the lungs. Values below the normal arterial $PO_2$ (arterial hypoxemia) are usually caused by pulmonary, circulatory, or respiratory abnormalities (e.g., bronchial obstruction, vascular problems, decrease in cardiac output, increased oxygen demand, anatomical heart defects, low inspired $O_2$ content). Generally, $O_2$ levels above 100 mmHg do not contribute significantly to the oxygen content since, with normal hemoglobin concentrations, 80 - 100 mmHg, $PO_2$ provides a 97% saturation level, and a level greater than 100% cannot be achieved.

B. Specimen:
1. Conditions for preparation of patient:
   Blood collection with syringe: None.
   Capillary blood specimens: should be collected in capillary tubes after warming the area or otherwise stimulating it to promote arterial circulation before skin puncture. Skin puncture should be deep enough to ensure free and rapid flow of blood.

2. Type of specimen, amount and acceptable containers:
   a. Minimum sample volume: 0.5 mL of blood using a syringe containing dry lithium heparin.
   b. Capillary blood specimens should be collected with capillary tubes with lithium heparin having a minimum fill volume of 125 µL.

   Do not use clay-capped capillary tubes. The rough, broken edge left after the capillary tube is cut may damage the OPTI cassette fill port. Use only capillary tubes with fire-polished ends to prevent cassette damage.

   If a mixing “flea” is used, remove the “flea” prior to sampling to avoid cassette damage.

3. Stability:
   Syringe: Blood gases and pH content will change due to cellular metabolism if the specimen remains at room temperature for more than 30 minutes. If the sample will be run within 30 minutes of collection, do not place on ice. If the sample is run more than 30 minutes after collection, place the sample in an ice slurry.

   $PO_2$ changes due to oxygen consumption may be influenced by several factors, including: WBC count, reticulocyte count, storage temperature and initial $PO_2$ value. Samples expected to have high WBC count, reticulocyte count, or high $PO_2$ values should be analyzed as soon as possible after collection.

   For specimens stored at 1 – 5° C, results are valid for up to 2 hours.

   Specimens obtained in plastic syringes may have higher $PO_2$ values than normal.
Particular attention should be paid to cooling blood samples in ice water, because of the CO₂ and oxygen solubility in some plastics. If blood specimens are expected to have very high PO₂ values, the specimen should be analyzed as quickly as possible following collection to avoid the need for cooling.

Capillary: Capillary specimens are stable at room temperature for up to 30 minutes after collection because of rapid cooling of the sample that occurs during capillary tube filling.

Errors in blood analysis on properly collected samples may result from improper mixing of the sample after collection and before measurement, contamination of the sample with room air because of failure to expel trapped air bubbles after collection, and from ongoing cellular metabolism within the sample.

4. Criteria for unacceptable specimen and action to be taken:
Clotted and any other anticoagulated samples are unacceptable and cannot be tested.

C. Instrumentation and Apparatus:
Order from Osmetech, 235 Nembree Park Drive Rosewell, GA 30076; telephone 1-800-490-6784.

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<th>Part description</th>
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D. Calibration:
Each lot of OPTI cassettes is calibrated during the manufacturing process. For pH, high precision standard solutions spanning the operating range for pH are used. For O₂ and CO₂, specially targeted calibration standards focusing on the clinically critical ranges are used. Calibration information, lot number and expiration date is contained within the "bar code" label on the package for individual cassettes.

Prior to running a sample, the cassette's relevant information is read into analyzer by 'swiping' the bar code on the cassette package through the bar code reader. The cassette is then installed and a calibration verification is performed with a precision gas mixture and the cassette's internal storage buffer. An optical zero point calibration of all optical channels is also performed.

During the calibration and measurement processes, diagnostic tests are automatically performed to assure correct operation of the instrument and cassette. These tests include automatic checks of the cassette for packaging integrity, temperature control, fluids control during calibration, proper equilibrium behavior of the sensors during calibration and measurement, automatic detection of bubbles and short sample during aspiration, and automatic detection of low gas, low battery, dirty optics, or worn pump.
E. Quality Control:

1. Two levels of Standard Reference Cassettes (SRC) Controls: These special test cassettes contain a stable optical sensor simulator that is measured by the analyzer in exactly the same manner as any other cassette. The SRC controls provide assurance that all measured parameters are consistent.
   a. Control frequency: two levels of SRC controls once daily
   b. Tolerance limits: as stated by manufacturer.
   c. Store controls at 15 - 30 °C.

2. Three levels of OPTI-check controls
   a. A minimum of one liquid control is run each week. The control levels are rotated each week. The testing personnel are also to be rotated. Each user is to perform at least one successful liquid control per year.
   b. A level 1, level 3, and 2 patient sample comparisons are run for new lots of AVL sensor cassettes.
   c. Store controls at 15 - 30 °C.

3. Patient comparisons are run between the OPTI CCA and the Omni Blood Gas instrument as scheduled at San Francisco General Hospital STAT Lab.

4. Quality Control Schedule:
   a. The schedule of quality control tasks is listed on the daily worksheet.
   b. The worksheet will list which controls or patient comparisons are to be performed for that day.
   c. The completion of each task is to be documented on the daily worksheet by signing the user’s initials.

5. Corrective action when controls are out of limits:
   a. SRC failure:
      i. Gently clean the SRC, the optics window, and the inside cover of the SMC.
      ii. Rerun SRC.
      iii. If it fails again, use an SRC with the same lot number from another OPTI (if available).
      iv. If SRC still fails, remove OPTI from service and notify the supervisor for your department.
   b. Liquid Control failure:
      i. If control fails, check the following:
         01. The wrong control may have been run. Select review and check the control level and lot number. If the wrong control was entered, it may be corrected. The QC will give a FAIL message. Press ESC and go to REJ/EDIT. Follow the directions and enter the correct lot number for the QC that was run. Press ENTER twice and accept the results. The QC should now print with the correct Lot # and values. If the lot number on the ampoule does not match any lot number on the display, REJECT by pressing escape and run a control with the correct lot number.
         02. If any of the results are outside of the OPTI’s measurement range, yielding a “LOW” or “HIGH” message, the results cannot be accepted to the controls database. In this case, the results are automatically rejected.
         03. Gently clean the optics window and the inside cover of the SMC.
         04. Repeat, checking lot number and expiration date.
         05. If the liquid control is still does not pass, remove from service and notify the supervisor for your department.
   c. Document all action taken and initial appropriate area on maintenance sheet.
F. Procedure:

1. Running an SRC measurement:
   a. From the READY display, select Menu by pressing ENTER.
   b. Press the ← or → until SRC is blinking. Press ENTER to select.
   c. If the OPTI displays:
      
      **SRC measurement** **SECURE**
      **Please enter PIN:**
      
      the secure ID features is implemented on your OPTI. Enter your 4 digit PIN and press ENTER. On the result printout the OPTI will print the operator ID associated with the 4 digit PIN that is stored in its memory; the operator’s ID is kept confidential.

      If the OPTI displays:
      
      **SRC measurement**
      **Op ID:**
      Enter your operator ID and press ENTER.

   d. Open the sample chamber cover by pressing the button. Examine the SRC to ensure it is clean and insert it into the chamber. Insure the lot number on the cassette matches the lot number on the pouch. Press down to properly seat the SRC.

   e. Close the sample chamber cover. After the cover has been closed, the instrument will automatically detect which level of SRC has been inserted and prompt you to verify the level and lot number. This information can be found on both the SRC cassette itself and its storage pouch. If the information shown on the display is correct, press ENTER to continue. If this information is incorrect, press ESC to interrupt this sequence and return to the RUN menu. Refer to OPTI CCA Operator Manual Section 3.4.2, for setting up the Standard Reference Cassette (SRC).

   f. After you have verified that the SRC information is correct, the instrument begins the measurement process (~60 seconds) and indicates so on the display screen. A countdown is displayed on the upper right hand corner.

   g. At the end of the countdown, the unit displays the results. Pressing ENTER allows you to scroll through the various results. Pressing ENTER after the third result screen will start the printing process. Pressing ESC at any time after the first set of test results has been displayed will start the printing process.

   h. The unit automatically checks the result against the acceptable ranges and stores the results in its internal database.

   i. If all parameters are within range, PASS will be displayed and printed. Enter the SRC lot number and initial the SRC PASS column on the daily worksheet.

   j. FAIL will be displayed if one or more parameters are out of range or if an internal drift is detected.

   k. If the SRC test fails follow procedure V. Quality Control, E. Corrective Action.

   l. Press ESC three times to return to the READY display.

2. Running OPTI-check Control:

   a. From the READY display, select Menu by pressing ENTER.

   b. Press the ← or → until **Controls** is blinking. Press ENTER to select.

   c. If the OPTI displays:
      
      **Run Control** **SECURE**
Please enter PIN:
the secure ID features is implemented on your OPTI. Enter your 4 digit PIN and press
ENTER. On the result printout the OPTI will print the operator ID associated with the 4 digit
PIN that is stored in its memory; the operator’s ID is kept confidential.

If the OPTI displays:
Run Control
Op ID:
Enter your operator ID and press ENTER.

d Press the ← or → until the desired level is blinking.
e Press ENTER to select and go to the next display. Press ENTER if the lot number is correct.
f Swipe the bar coded strip on the OPTI Cassette package through the bar code reader (on the
right hand side of the analyzer) to automatically record the lot and calibration information the
specific cassette. The unit will beep and the status light will turn green to confirm you have a
valid bar code. In the case of an expired cassette, the light will turn red. If the bar code is
damaged or unreadable, use the keypad to enter the bar code digits printed on the bar code
label.
g Tear open the cassette pouch, being careful not to tear the bar code. Remove the cassette
and wipe any excess moisture from the cassette with a clean dry cloth.
h Open the sample chamber cover by pressing the release button.
i Insert the cassette into the chamber. Press down to ensure that the cassette is seated
properly. Close the sample measurement chamber (SMC) cover.
j The system starts to calibrate. The green status light is now lit, indication that a measurement
is occurring and that the sample chamber cover should not be opened. If the SMC cover is
opened while the green status light is blinking, the cassette calibration will be canceled and
the cassette must be discarded.
k After calibration is completed, remove an ampoule from the box of controls and shake gently
to re-suspend the scattering particles, being careful not to heat it with your hands.
l Gently tap the head of the ampoule with your fingernail to remove any liquid. Carefully open
the ampoule by breaking off the top. Protect your fingers by using gloves and gauze while
breaking the ampoule.
m Invert the ampoule 45° and inset into fillport and press ENTER. The QC sample is aspirated
into the cassette and the measurement starts. At this time the status light begins flashing
green indicating that the cover should not be opened. Upon completion of the measurement
the results are displayed.
n Review the results. The display will show PASS or FAIL. The instrument will flag values that
are above or below the programmed ranges by placing an up or down arrow next to the
parameter label.
o If PASS, press ENTER to advance to the next results screen. Press the ← or → until ACCEPT
is blinking. Press ENTER to accept the results and save them within the control database.
p If Opti-Check control fails, follow procedure V. Quality Control, E. Corrective Action.
q Initial appropriate area on Daily Maintenance sheet.
r Open the sample chamber cover and remove the cassette.
3. Running a patient sample:

   Prior to analyzing a patient sample, a "high" and "low" Liquid Quality Control must be performed. The "high" QC#3 is run prior to the ABG and the "low" QC#1 is run after the ABG. This is now a requirement for every Arterial Blood Gas performed. "Pre-ABG" and "Post-ABG" is written on the QC printout of each sample and placed in the "Weekly Controls Pre and Post Folder". Weekly Controls will continue to be performed on Wednesday's per the schedule posted in the Respiratory Therapy Department.

   a) Turn on the OPTI and wait until the READY display appears. When READY appears, the unit is ready for sample measurement. During warm-up, the OPTI checks the gas pressure. If the pressure is too low, a warning will appear alerting you to low gas or no gas. If no gas remains, refer to OPTI CCA Operator’s Manual Section 6.5.1 to install a new gas bottle.

   b) Take a sensor cassette pouch and swipe the bar code across the bar code reader.

   c) The bar code should face the instrument. A beep and a green status light indicates a valid bar code. A red status light indicates an invalid bar code (e.g., cassette expired). Observe the analyzer display for detailed information.

   d) Remove the cassette from pouch. Avoid tearing the bar code when opening the cassette pouch.

   e) Gently wipe both sides of the cassette with a clean dry cloth to remove excess moisture. Press the sample measurement chamber cover release button to open the chamber.

   f) Insert the cassette in the chamber. Press down to ensure the cassette is properly seated. Close the sample measurement chamber (SMC) cover.

   g) The system starts to calibrate. The green status light is now lit, indication that a measurement is occurring and that the sample chamber cover should not be opened. If the SMC cover is opened while the green status light is blinking, the cassette calibration will be canceled and the cassette must be discarded.

   h) The system will now check the integrity of the cassette and then calibrate. The OPTI will hold the calibration for 10 minutes. After this time elapses a message will be displayed to discard the cassette.

   i) When the display prompts the user to mix and place the sample, mix the syringe sample well by rolling it between the palms of your hands and inverting and over end.

   j) Expel some sample to check for clot. Attach the sample to the cassette filiport and press ENTER. The sample is then aspirated. Do not inject the sample. It will be automatically aspirated.

   k) During the sample measurement, the status light is blinking and a countdown of the measuring time remaining is displayed in the right hand corner of the screen. The sample cover should not be opened during the sample measurement.

   l) To enter patient information, press ENTER when display indicates ready for input of patient data. Enter Patient and operator ID (or PIN if Secure ID is implemented).

   m) Press ESC at any time to exit the menu. If no value is entered, a default value will completed, the status light stops blinking and the results are displayed indicating that the measurement has been completed.

   n) Press the ← or → until keys to view calculated parameters. Press ENTER to display the second set of result with their associated calculated parameters.

   o) The OPTI Analyzer flags values that are above or below the programmed ranges with an up or down arrow. If the value is outside the measurable range a HIGH or LOW will be displayed and a >" or a "<", with ranges printed out on the patient report.

   p) Open the cover or press ESC and remove the cassette to go to next sample. To edit the patient data press ENTER.

According to the California Department of Public Health, CMS (Centers for Medicare and Medicaid Services) and CLIA (Clinical Laboratory Improvement Amendment) requirements include participation in Proficiency Testing to assure quality assurance for reporting test results.

There are many ways this can be achieved, however we participate in the Proficiency Testing product offered by the College of American Pathologists (CAPS) and have tested with this product for several years.

This is "blind" testing procedure is performed every four (4) months. Once the testing material is received, it is performed and values are documented and sent back to CAPS where data is compiled from other participating organizations. A passing score for overall testing is 80%, regulation standards set by CMS / CLIA.

Returned results that do not meet required regulation standards will be acted on as soon as possible, notifying the departments Medical Director, contacting CAPS for re-supply of testing material (if available) and the manufacturer of the device used at Laguna Honda Hospital Osmetech.

G. Calculations:

H. Reporting Results:
1. REFERENCE RANGE – arterial whole blood
   - pH: 7.35 – 7.45
   - PCO₂: 35 – 45 mm Hg

   Actual Bicarbonate (plasma)
   - 22 – 26 mmol/L

   CO₂ Content (plasma)
   - 23 – 27 mmol/L

   PO₂
   - Adults: 80 – 100 mm Hg
   - Over age 65: 75 – 85 mm Hg
   - Newborn: 60 – 70 mm Hg

2. REFERENCE RANGE – venous whole blood
   - pH: 7.32 – 7.42
   - PCO₂: 41 – 51 mm Hg

   Actual Bicarbonate (plasma)
   - 24 – 28 mmol/L

   CO₂ Content (plasma)
   - 25 – 29 mmol/L

   PO₂
   - Adults: 25 – 40 mm

3. REPORTABLE RANGE (manufacturer)
   - pH: 6.600 – 7.800
   - PCO₂: 10.0 – 200.0 mm Hg
   - PO₂: 10 – 700 mm Hg
4. CRITICAL RESULTS

pH: < 7.25 – > 7.55
PCO₂: < 20 – > 50 mm Hg
PO₂: < 55 mm Hg

I. Limitations of Method:
1. Dilutions: N/A
2. Interferences:
   a. Heparin salts are the only acceptable anticoagulant. Other anticoagulants such as citrate, EDTA, oxalate, and fluoride cause significant interference with the pH sensor.
   
   b. Other Interferences:
      | Substance          | Amount:     | pH change:
      |--------------------|-------------|--------------
      | Sodium Fluorescin  | 26 mg/dL    | unstable     |
      | Cardio (indocynine| 0.5 mg/dL   | -0.04        |
      | green              |             |              |
      | Methylene Blue     | 25 mg/dL    | -0.16        |
   
   c. Iced samples do not cause any measurable sensitivity.

J. Preventive Maintenance:
1. Annual preventive maintenance is performed by Biomedical Engineering.
2. Daily, weekly and monthly preventive maintenance is listed on the daily worksheet. Initial any preventive maintenance task listed on the maintenance sheet after it is completed.

K. References:

L. Distribution:
A. Point of Care Master Procedure Manual, Rm 2M14
B. Respiratory Care Services, Rm GA2
C. Anesthesia Service
D. LHH Respiratory Care Services.

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