List of Hospital-wide/Department Policies & Procedures

Submitted to JCC for Approval on July 14, 2015

1. ***New Policies and Procedures (P & P)***		
Hospital-wide: Laguna Honda Hospital Policies & Procedures (LHHPP) approved by NEC, MEC and/or HEC		
Policy Number	**Title**	**Comments/Reason(s) for Policy & Procedure Development**
LHHPP 70-04	**Code Silver – Active Shooter**	To provide guidance for responding to the presence of an active shooter situation.
2. ***Revised Policies and Procedures***		
Hospital-wide: Laguna Honda Hospital Policies & Procedures (LHHPP) approved by NEC, MEC and/or HEC		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
LHHPP 01-01	**Approval and Format of Hospital-wide and Departmental Policies and Procedures**	Revised to improve the approval process by modifying policy statements # 2, 3, 4, 6 and 8; with changes to the following procedures: i) sequence to the policy and procedure approval process, ii) clarification of the phrase "impact clinical care services" to mean "impact disease/clinical care management" requiring Nursing and Medical Executive Committee approvals prior to implementation, iii) establishes approval procedure by the Hospital Executive Committee on hospital-wide administrative policies and procedures; and iv) creates a list of minor revisions that do not require Joint Conference Committee approval
LHHPP 01-11	**Standard Formatting Template for Policies and Procedures**	Adds detailed formatting procedures for consistency
LHHPP 21-01	**Medical Records Information: Confidentiality and Release**	Minor revisions related to Procedures # 5 and 6 on the validity of authorizations for release of resident health information and the use of the "Release of Information Module" for tracking the status of resident health information requests
LHHPP 21-06	**Transporting the Resident's filed Medical Record**	Minor revisions replacing the word "chart" with "medical record" and adding immediate notification to Health Information Service (HIS) staff when any part of the medical record is discovered to be missing
LHHPP 21-07	**Handling Misfiled LCR Reports/ Notes**	Retitled "Handling Erroneous Electronic Health Record Entries." Adds a procedure for entering an addendum note to disregard an erroneous electronic entry that has been signed, locked and cannot be removed from view; and revises the submission of a monthly report to the Health Information System Committee (formerly known as the Medical Record Committee) instead of to the Committee Chair or HIS designee on the status of erroneous electronic health record entries

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LHHPP 22-02	**Resident Alcohol Consumption**	Enhances procedures by specifying physician role in discussing effects of alcohol use with the resident, family and staff, if necessary, and adds resident circumstances when resident referral for Substance Abuse Treatment services is indicated
LHHPP 22-05	**Handling Resident's Property and Prevention of Theft and Loss**	Procedural changes are added to enhance staff accounting of residents' property by 1) completing an annual inventory of residents' belongings, 2) requesting engraving of resident dentures for identification, and 3) providing clear description of lost event and item(s) when submitting an incident report. Revision to Procedure # 7 also clarifies the limitation of Laguna Honda's liability on resident property loss.
LHHPP 29-06	**Guidelines for Handling Decedents and Use of Morgue**	Re-written to reflect current policies and procedures for releasing the remains of the deceased, completion of the death certificate, and monitoring the morgue capacity by reviewing and updating the morgue database
LHHPP 29-09	**Accommodation of the Family After Patient's Death**	Re-written to better explain the reason why Health and Safety Code Section 1254.4 is not applicable to Laguna Honda because the facility does not provide services for ventilator support
LHHPP 55-03	**PASRR**	Procedures for completing Pre-Admission Screen and Resident Review (PASRR) assessments, Level II referrals to the Department of Mental Health (DMH) and Department of Developmental Services (DDS), and obtaining Level II DMH and DDS reports are revised to reflect the new California Department of Health Care Services (DHCS) PASRR web-based system and process
LHHPP 76-01	**Secured Neighborhood Safety Standard**	Revised to enhance safety standards and procedures on the North Mezzanine neighborhood
Department: Nursing Policies and Procedures (NPP) approved by NEC and MEC		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
NPP B 9.0	**Documenting/Reporting Resident Allergies**	Title expanded to Documenting/Reporting Resident Allergies/Adverse Drug Reactions. Verbiage change in policy, purpose statements and procedure includes "adverse drug reactions". Added in the procedure documentation of new allergies for an established resident in the EHR and physician's order sheet.
NPP C9.0	**Transcription and Processing of Orders**	Major revision on policy statements including medication orders written electronically; additional providers who are authorized to give and accept verbal orders. Simplify purpose statement. Verbiage changes made in the procedure sections and reference made to other hospital-wide P&Ps which pertains to verbal/telephone orders. Procedure section G includes monthly review of written orders with eCW orders. Deleted section regarding physician order processing correction

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		request. Updated cross-references and deleted original appendices.
NPP D5 1.0	**Foot Care**	Verbiage change in policy and purpose statements and procedure section.
NPP D5 4.0	**Arm Sling**	Minor verbiage change in the document. Added to policy statement, "physician will determine duration of use". Updated reference.
NPP H1.0	**Collection of Urine Specimen**	Minor change in verbiage in policy statements. Added to policy, LN will notify physician if the specimen cannot be obtained. Change in purpose statement. Change in procedure section C, revision reflect methods of collecting urine specimen via midstream technique, intermittent, and indwelling catheters. Created 2 attachments to describe the procedure in collecting midstream and intermittent catheterization. Updated references and cross-references. Disposition of Urine Specimens: Procedure 1 and 3 corrected to reflect what the process with STAT labs is currently. Attachment 1: Urine Collection using Midstream (Clean-Voided) Technique - Attachment 2: Urine Collection using Intermittent Catheterization
NPP H6.0	**STAT or Routine Clinical Laboratory Protocol**	Major revisions made, simplified and only reflected guideline for nurses for STAT blood draws. Deleted most of the information as it appears to be a duplicate of Clinical Laboratory P&P. Title change to After Hours STAT Blood Draw. Other changes include (1) Licensed Nurse will perform blood draw for STAT orders when lab technicians are not available or after hours. (2) STAT blood results are viewed on the electronic medical records. Updated cross-references. Recommended to separate the "Special handling of laboratory specimen" as an appendix.
NPP J1.1	**Obtaining, Handling, and Storage of Medications**	Changes include minor verbiage change in policy statement. Change in procedure section B # 1 to new medication orders will be transmitted to pharmacy via electronic prescription via HER or fax; minor verbiage change in checking meds in the refrigerator. Updated cross- references.
NPP K 9.0	**Management of Resident on Hemodialysis**	Changes made to reflect new practice of communicating with dialysis center through secured fax communication form. Added policy statement # 6 to checking the AV shunt at least daily and reporting changes to physician. Deleted procedure section E "Care Between Dialysis Treatment" as the procedures were incorporated in sections A & B; and Section F minor verbiage change. Updated references. Appendix 1: Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis - Reflect use of dialysis communication form. No further changes. Appendix 2: Dialysis Communication Form – existing form.

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		Appendix 3: Dialysis RCP - Revised to reflect use of dialysis communication form. Appendix 4: Dialysis TAR Template
Department: Pharmacy (Pharm) approved by NEC and MEC		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
Pharm 04.01.00	**Safety and Emergency Preparedness Plan**	Minor revision to reflect increased frequency of departmental safety check (monthly vs quarterly) and revision of check list (attachment).
Pharm 04.01.01	**Duties and Responsibilities during Disasters and Disaster Drills**	Revised to reflect current practice during disaster drills of centralized pharmacy services. Removal of disaster drug kits.
3. *For Deletion*		
Hospital-wide: Laguna Honda Hospital Policies & Procedures (LHHPP) approved by NEC, MEC and/or HEC		
Policy Number	**Title**	**Comments/Reason(s) for Deletion**
None	**N/A**	N/A

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CODE SILVER – ACTIVE SHOOTER

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to the prevention of workplace violence when at all possible. Laguna Honda is also committed to providing a response plan for an active shooter situation.

PURPOSE:

The purpose is to provide guidance for responding to the presence of an active shooter at Laguna Honda.

DEFINITION:

An active shooter is defined as any person or persons who is/are actively engaged in killing or attempting to kill people in the hospital or on the hospital campus. The weapon(s) typically involve use of firearms, but may include other weapons such as knives or explosive devices.

PROCEDURE:

1. Situation

This plan applies to situations in which an active shooter is on the Laguna Honda campus. An active shooter may have a target victim, but often displays no pattern or method for selection of their victims.

2. Employee Responsibility

All employees must take responsibility for their own survival in the event of an active shooter entering their work area. You can prepare yourself to maximize your chance of survival by:

a. Being familiar with the work area;

b. Knowing the route to the two nearest exits; and

c. Having a plan for barricading in place.

3. General Response – Run…Hide…Fight

a. Run: In the event that a person is actively killing or attempting to kill people in the facility, the best action to take to maximize your chance of survival is to run.

b. Hide: If you cannot escape, the next best option is to hide. Do not come out until the Sheriff from the San Francisco Sheriff Department (SFSD) notifies you that CODE SILVER is all clear.

c. Fight: As a last resort and only when you are in imminent danger, try to overpower or incapacitate the shooter.

4. If a Shooter Enters Your Work Area

a. Run to safety if possible.

b. If you cannot escape, try to remain calm.

c. Hide or get behind something that will provide some concealment if shots are fired in your direction.

d. Try not to do anything that will provoke the shooter(s).

e. If there is no possibility of escaping or hiding, as a last resort and only if your life is in imminent danger, you may choose to try to negotiate with or overpower the shooter(s). If you choose to fight:

   i. Commit to your decision and act as aggressively as possible toward the shooter.
   ii. Improvise weapons using things like fire extinguishers or sharp instruments.
   iii. Yell and throw things at the shooter.

f. If the shooter leaves the area, barricade the room or get to a safer location and call 911.

5. If You Are In a Location Distant From the Shooter

a. If you can get out of the building to escape the shooter, take care of yourself and get out, even if it means leaving the residents

b. Convince others to come with you if possible. Do not let anyone convince you to stay.

c. Leave your belongings.

d. Call 911 when you are safely out of the building.

e. If you cannot get out of the building, close doors and barricade yourself and others in a room if possible.

f. Hide or get behind something that will provide concealment if shots are fired in your direction.

g. Turn off the ringer on your cell phone and other sources of noise.

h. Call 911 if it is safe to do so (see procedure 6a for information to provide). If speaking will reveal your hiding place, leave the line open so the 911 operator can hear.

i. Do not open the door or leave your hiding place until you hear that Code Silver is all clear.

6. Notification and Incident Command

During any active shooter incident, it is important to notify all hospital occupants of the situation and alert law enforcement as quickly as possible.

a. Call 911 if you are able to do so safely. Provide as much information as possible to the dispatcher, including:

   i. Location and description of the shooter(s)
   ii. Number of shooters and number and type of weapons
   iii. Number of victims and/or hostages

b. 911 dispatchers will notify the Laguna Honda Sheriffs immediately.

c. The Laguna Honda Sheriffs' Office will establish the Incident Command Post and the ranking officer on duty will be the Incident Commander.

d. The SFSD staff will announce via overhead page:

   ATTENTION: CODE SILVER – ACTIVE SHOOTER [LOCATION].
   TAKE COVER. LAW ENFORCEMENT IS ON THE WAY.

e. The SFSD staff will also send an electronic notification to department managers via Everbridge. Department Managers are responsible for communicating the Code Silver to anyone who does not hear the overhead page.

f. The Sheriffs will make other necessary announcements overhead or using Everbridge at any time during the incident. Staff are to follow the SFSD staff's directions.

g. When the shooter is apprehended or leaves the campus, the Sheriff will announce overhead that Code Silver is all clear.

h. The Executive Administrator or AOD will activate HICS to manage the recovery until resumption of regular operations.

ATTACHMENT:
None

REFERENCE:
Laguna Honda Hospital Code Silver Active Shooter Response Guide *(pocket guide)*

The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Partnership's "Active Shooter Planning and Response in a Healthcare Setting", Draft January 2014.

Revised: N/A
Original adoption: 15/07/14

INFORMATION YOU SHOULD PROVIDE TO 759-2319 SFSD OPERATOR (AT LHH) OR 911 AND ARRIVING LAW ENFORCEMENT:

Location: Building – Floor - Room
Number of shooters
Descriptions – Race, Gender, Age & Height, Weight, Hair Color
Type(s) of weapon(s)
Carrying backpack or duffel bag?
Where is the shooter now?
Where was shooter last seen?
Direction of travel
Do you recognize the shooter?
If so, provide name.
Any explosions besides gunshots?
Number of people at your location.
Any injuries? Number & types.

Code Silver = Active Shooter → Run to Safety or Immediately Barricade in Place.

No Hospital Command Center Activation & No DOSRs Until Shooter Apprehended

Remain Barricaded Until You Are Given Further Instructions.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Laguna Honda Hospital

Code Silver

Active Shooter Response Guide

BE PREPARED TO DEAL WITH AN ACTIVE SHOOTER SITUATION:

Be aware of your environment.

Be vigilant regarding any unusual or suspicious activities.

Be familiar with your usual work area. Know where and how you could barricade in place to protect yourself and your patients.

Look for the two nearest exits in any facility you visit.

IF A SHOOTER ENTERS YOUR VICINITY:

Remain calm.
Try not to provoke the shooter.
Escape or hide if you can.
ONLY AS A LAST RESORT WHEN YOUR LIFE IS IN IMMINENT DANGER, attempt to negotiate with or overpower the shooter.
If you choose to take action, be decisive, quick and physically aggressive trying to incapacitate the shooter.
If the shooter leaves the area, barricade in place or escape to a safer location.

IF THE ACTIVE SHOOTER IS NOT AT YOUR LOCATION:

Remain calm.
Warn others to immediately take cover and barricade in place.
Lock and barricade or block doors and windows.
Keep everyone out of sight. Take cover behind concrete walls, heavy desks, or filing cabinets.
Silence your cell phone & pager.

IF YOU ARE OUTSIDE:

Remain calm.
Move away from the shooter or the sound of gunshots.
Take cover behind thick walls or parked vehicles.

WHEN POLICE ARRIVE:

Remain calm.
FOLLOW OFFICERS' INSTRUCTIONS EXACTLY.
Drop anything you are holding, raise your hands and spread your fingers.
Keep your hands visible.
Don't point, scream, yell or make any quick movements towards officers.
When evacuating, don't stop to ask for help or directions.
Medical assistance will be provided after the scene is safe.

Expect to be held in a safe location until the situation is under control and all witnesses have been identified and questioned.

AFTER A SHOOTING INCIDENT:

Account for all patients, staff and visitors.
Ensure everyone's safety, and provide medical care as needed.
Report anyone missing or injured along with your department's status to the Hospital Command Center / HICS Team.
Follow instructions from Law Enforcement and the HICS Team.
Assess the mental health needs of patients, visitors and staff and refer them for support as directed by the HICS Team.

APPROVAL AND FORMAT OF HOSPITAL-WIDE AND DEPARTMENTAL POLICIES AND PROCEDURES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center establishes, issues, and maintains Hospital-wide Policies and Procedures.

2. Laguna Honda Hospital and Rehabilitation Center Hospital-wide Policies and Procedures (LHHPPs) shall be implemented only after approval of the Executive ~~Administrator or designee~~Committee and the Joint Conference Committee; unless resident safety may be impacted.

3. Every Department Head is responsible for ~~will prepare and~~ maintaining a current manual of their Departmental Policies and Procedures (DPP).

4. DPPs that impact ~~clinical care services~~ disease/clinical care management require approval by ~~the Medical,~~Nursing and Medical Executive ~~and Nursing Executive~~ Committees prior to implementation.

5. LHHPPs and DPPs are reviewed at least every year in accordance with Title 22 requirements.

~~5.~~6. A standardized formatting template shall be utilized for hospital-wide policies and procedures (refer to LHHPP File: 01-11) ~~shall be recommended for use in developing new policies and procedures.~~

~~6.~~7. The file numbers of deleted LHHPPs may be re-assigned to newly developed LHHPP the following year after the annual review of process of LHHPPs for the calendar year.

~~7.~~8. Hospital areas that have access to the ~~CHN~~ San Francisco Health Network (SFHN)~~Internet~~ internet website are not required to ~~have a~~maintain a hard copy of the LHHPP or Nursing DPP.

PURPOSE:

1. To provide unified and consistent statements of Hospital-wide and Departmental policies and procedures.

2. To describe procedures for developing and reviewing departmental policies and procedures at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda).

CHARACTERISTIC:

1. A Hospital-wide Policy and Procedure describes activities or processes:

   a. which may be executed by a single department but must be understood or requested by more than one department;
   Or
   b. which must be both understood and executed by more than one department in order to be implemented

2. The Laguna Honda Hospital-wide Policies and Procedures have broad application. They do not focus on the function and systems of individual departments and divisions. LHHPPs define administrative responsibility and staff performance relating to specified administrative and resident/patient care functions.

3. A Departmental Policy and Procedure describes activities or processes:

   a. which occur within and need to be understood and executed only by the issuing department,
   Or
   b. which may occur Hospital-wide but which implementation or maintenance requires understanding and execution only by a single department.

PROCEDURE:

1. Hospital-wide Policies and Procedures (LHHPP)

a. New LHHPP may be generated by:

   i. The chairperson of a medical staff committee,
   ii. The administrative liaison to a medical staff committee,
   iii. The chairperson of an administrative/clinical committee,
   iv. The chairperson of an ad hoc committee, or
   v. A member of the Laguna Honda executive staff.

b. Revision of an existing policy and procedure may be initiated by the same person(s) identified above. The person initiating the revision shall request for the Word document of the LHHPP being revised from the Administrative designee, and use the track change document feature to mark the proposed changes in the document.

c. The draft of the new or substantially revised policy and procedure that impacts disease/clinical care management must be submitted to the following individuals:

   i. Chair ~~of the HEC (CEO)~~of Nursing Executive Committee (NEC)
   ii. Chair of ~~MEC (Chief of Staff)~~Medical Executive Committee (MEC)
   ~~iii. Chair of NEC (CNO)~~[iii.]Chief Medical Officer

~~iv.~~iii. Administrative designee (as determined by the Director of Quality Management), for coordination purposes.

d. New or revised administrative policies and procedures that are not performed~~carried out~~ by Nursing or Medical staff do not require NEC or MEC approval.

~~d.~~e. The Administrative designee shall be responsible for issuing new LHHPP file numbers.

~~e.~~f. The person authoring a new LHHPP is expected to utilize the standardized formatting template for developing policies and procedures when creating the new LHHPP.

~~f.~~g. The Hospital Executive Committee reviews and approves policies and procedures to ensure that the policies and procedure agree with the administrative philosophy and Department of Public Health guidelines.

~~g.~~h. The Medical Executive Committee and Laguna Honda Nursing Executive Committee shall review and approve all ~~clinical~~ LHHPP that impact disease/clinical care management to ensure that the procedures agree with sound medical, nursing or clinical practice.

~~h.~~i. Policy revisions and amendments that do not necessitate a substantial rewrite may be submitted to the Hospital Executive Committee with corrections superimposed on a copy of the current policy.

~~i.~~j. All new and revised LHHPPs requiring approval by Hospital Executive Committee, Medical Executive Committee and/or Nursing Executive Committee shall be sent to the respective chairs of these committees.

~~j.~~k. The Administrative designee will send the policy to appropriate individuals, committees, departments or services for review. This will help ensure that the policy agrees with current policies and practices and does not duplicate other policies. The following factors must be taken into consideration as appropriate in order to conduct a substantive review:

i. Relevance to other policies and procedures
ii. Relevance to standards of care and standards of practice,
iii. Ethical and legal concerns,
iv. Current scientific knowledge, and
v. Findings from quality improvements/assurance activities

~~k.~~l.

~~l.~~ The policy approval process ~~by the~~ shall be sequenced in the following order: Nursing Executive Committee, Medical Executive Committee, Hospital Executive Committee and the governing body as soon as practical. ~~Medical Executive~~

~~Committee, Hospital Executive Committee and Nursing Executive Committee may be done in any sequence, and review and approval will be made by the hospital's governing body as soon as practical.~~

m. When final policy approval is reached, the newly developed or revised LHHPP may be posted on the intranet.

n. The Administrative designee ~~will~~ shall place LHHPP on the calendar for an annual review by the Hospital Executive Committee.

o. All existing LHHPP ~~and DPP will~~ shall be submitted for an annual review to the Director of Public Health, ~~Administrator~~CEO, ~~Medical Director~~CMO, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager/Coordinator at the designated Policy and Procedure review meeting in August of each year.

p. Annual review and approval of existing LHHPP ~~and DPP~~ shall be scheduled for review and approval by the governing body as soon as practical.

q. The Hospital Executive Committee in conjunction with Division Heads and Department Managers are responsible for disseminating information to Laguna Honda staff about new policies and revisions of existing policies and ensuring that LHHPPs are implemented at the departmental level.

r. Hospital Administration is responsible for keeping a hard copy of the manual and the Quality Management designee is responsible for updating the manual.

s. The LHHPP Website:

i. The LHHPP is available on the Laguna Honda and ~~Community Health Network (CHN)~~ SFHN ~~Website~~website.
ii. The Website is maintained by the Laguna Honda Information Systems.
iii. Staff are educated and trained on how to access the Policy and Procedures on the ~~CHN~~ SFHN website.
iv. IS staff is responsible for archiving copies of the LHHPP on the designated shared network drive.

t. Manuals:

i. ~~A small number of h~~A hard copy~~y~~ LHHPP Manual~~s~~ will be available ~~throughout the Laguna Honda campus~~ in case the ~~CHN~~ SFHN Intranet is ~~temporarily~~ disrupted.
~~ii. The Manuals contain a table of contents for ease of reference and the policy and procedures are numbered and grouped by subject matter and listed in numeric order.~~

u. Communication:

i. Hospital Executive and managerial staff are responsible for disseminating information related to policy direction and revisions to their respective departmental staff.

2. Departmental Policies and Procedures (DPP)

a. DPP must be specific to the operation of each department and define the specific scope and activities of the Department in accordance with applicable state and federal regulations.

b. Department Heads may propose to transform a DPP to a LHHPP when appropriate.

c. Department Heads are responsible for:

i. Obtaining the approval of the responsible Division Head;
ii. Maintaining at least one copy in the Department Manager's office.
iii. Training employees to standards set forth in the manual.
iv. All existing DPP ~~will~~ shall be submitted for an annual review to the Director of Public Health, Administrator, Medical Director, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager at the designated Policy and Procedure review meeting in August of each year.

d. Each Department must have the following elements within their DPP, unless they are delineated by existing LHHPP:

i. Department structure and organization
ii. Scope of service
iii. Applicable policies required for licensing standards and by State and Federal regulations ,
iv. Policies and procedures pertaining to administrative, resident/patient, and medical care activities unique to the Department,
v. Protocols implementing or supplementing existing Laguna Honda personnel practices, and
vi. Education and training requirements

e. Department specific procedures may supplement existing LHHPP for the following areas:

i. Infection control guidelines,
ii. Departmental response to both internal and external disasters and emergencies (e.g., fires, mass casualty disasters, and power failures), and
iii. Performance improvement,
iv. Environment of care,
v. Contract requirements (i.e., managed care contracts)

vi. Health and safety requirements

f. Approval Process for DPP

i. The Department Manager/Director gives the initial approval for the policy.
ii. When the implementation of a DPP involves other Departments, the Department Managers of these Departments review, comment, and approve the development or revision of the Policy or Procedure.
iii. When DPPs impact ~~clinical care services~~ disease/clinical care management, the appropriate health professional and administration shall be consulted, and the new or revised DPP shall be implemented after review and approval by ~~the~~ Nursing and~~,~~ Medical ~~and~~, Executive ~~and Nursing Executive~~ Committee.
iv. DPPs also require review and approval by the hospital's governing body as soon as practical.

g. Implementation of DPP

i. The Department Managers are responsible for implementing DPP and for ensuring that the current DPP are readily accessible to all staff.
ii. Retention of the Policy and Procedures Archives
iii. The Department Manager of each unit is delegated the responsibility for retaining original versions of all DPP for seven (7) years from date of origin, revision or deletion.

3. List of Minor Revisions Not Subject to JCC Approval

a. Refinements to formatting and layout;
b. Correction of typographical errors;
c. Correction of grammar and punctuation;
d. Changes to procedure titles;~~.~~
e. Renumbering of policies and procedures.

ATTACHMENT:
None

REFERENCE:
LHHPP 01-10 Departmental Responsibility and Accountability
LHHPP 01-11 Standard Formatting Template for Policies and Procedures

Revised: 08/07/22, 10/08/24, 10/12/03, 13/05/28, 13/09/24, 15/07/14 (Year/Month/Day)
Original adoption: 5/20/1992

STANDARD FORMATTING TEMPLATE FOR POLICIES AND PROCEDURES

POLICY:

A standardized formatting template shall be followed in developing and revising Hospital-wide policies and procedures.

PURPOSE:

To provide consistency in formatting policies and procedures.

PROCEDURE:

1. **Page Set-Up**
   a. Open word document and apply the following setting:
      i. Header and Footer – 0.5”
      ii. Margins – 1” Top, 1” Bottom, 1” Right, 1” Left
      iii. Orientation – Portrait

2. **Headers and Footers**
   a. Under view setting click on Header and Footer and apply the following format to your Header:
      i. Arial 10 Font
      ii. Apply a bottom border by using the grid from your toolbar.
      iii. Center the header contents so that comparable blank space remains at the top and at the bottom of the Header to accommodate Headers with extensive content.

   b. Under view setting click on Header and Footer and apply the following format to your Footer:
      i. Arial 10 Font
      ii. Apply top border by using the grid from your toolbar.
      iii. Insert Auto Text Menu – Insert Page X of Y

   c. Keep the footer and header aligned.

   d. Titles or description of headers and footers
      i. Top left: Indicate File Number and Title of the Policy and Procedure; ensure the file number is correct, especially for renumbered Policies and Procedures. Contact Quality Management Dept. if necessary.

ii. Top right: Indicate New, ~~or~~ Revised, or Deleted and the date of approval by the Joint Conference Committee (JCC)
iii. Bottom left: Specify Laguna Honda Hospital-wide Policies and Procedures
iv. Bottom right: Specify page numbers

3. Title

a. Apply the following format options to the Title (Name of a Policy or a Procedure):

i. Arial 14 Font
ii. All Caps
iii. Bold
iv. Left Alignment

b. Use the singular noun form to title sections of the policy and procedure (e.g. Policy, Purpose, Procedure, Header and Footer, Attachment, Appendix, and Reference).

4. Policy, Purpose and Procedure

a. The Policy statement shall be stated at the beginning of each policy and procedure, followed by the Purpose statement.

b. If more than one Policy and Purpose statements are stated, they shall be numbered.

c. The Procedure section describes the steps for carrying out the policy or policies and meeting the purpose statement(s).

5. Body Content

a. Apply the following format options to the Body:

i. Arial 12 Font
ii. Justified Alignment

b. Sections in the body (i.e. POLICY, PURPOSE, PROCEDURE~~S~~, ATTACHMENT~~S~~/APPENDIX, REFERENCE~~S~~) are formatted as follows:

i. Arial 12 Font
ii. All Caps
iii. Bold
iv. Left Alignment

c. Subjects in the body (i.e. Page Set-Up, Headers and Footers, Title Content, etc.) are formatted as follows:

   i. Arial 12 Font
   ii. Bold (~~-~~when applicable, with the exception of Subjects that are in the form of a paragraph or multiple sentences).

6. Bullets and Numbering

a. The Procedure section shall apply the following listing format:

   i. Outline Numbered: 1., a., i, ●, ●

b. Apply Bold Setting to Subjects (primary listing 1., 2., 3., etc.) when applicable.

7. Attachments~~-~~/~~-~~Appendices

a. List Attachments and/or Appendices in ascending order. Indicate None if there are no attachments.

b. Whenever possible, insert the appendices into the MS Word version of the policy/procedure as MS Word text or as a tif image. Otherwise, submit the appendices as separate MS Word documents along with the policy/procedure.

~~b.~~ c. Ensure Attachments/Appendices are correctly identified.

8. References

a. List references in numeric order when the reference relates to a policy number, otherwise list in ascending order. Indicate None if there are no references.

   i. Check all policy numbers used as references to ensure their accuracy.

b. Ensure References are correctly identified.

9. Dates: Most Recent Review, New, Revised, Deleted, Original Adoption ~~Dates~~

a. Date format to be used is (Year, Month, Day)

b. Most Recent Review date
   i. The most recent review date shall no longer be required to be stated on the policy and procedure. Delete the Most Recent Review section, if necessary, from a policy and procedure being revised.
   ii. The most recent review date is the later of the annual policy and procedure review date or the most recent revision date.

c. New, Revised, Re-numbered and Deleted date(s)

i. Indicate New, ~~or~~ Revised, or Deleted at the top right corner of the policy and procedure.
ii. Beginning December 3, 2010, the new, ~~or~~ revised, and deleted date reflects the date when the JCC approved the ~~revision the~~new, revised, or deleted policy and procedure.
iii. At the end of the policy and procedure, indicate N/A for a new policy and procedure
iv. List the dates of all prior policy and procedure revision
~~iv.~~v. When a policy and procedure is re-numbered, specify the old and new policy and procedure number next to the revision date.
~~v.~~vi. Do not delete any dates that have previously been listed

d. Original adoption date
i. This date reflects the date when the policy and procedure was first approved by the Division Head or Executive Committee or when the policy and procedure was first implemented.
ii. This date does not change.

10. Proofreading

a. Proofread document in its entirety for typographical and formatting errors.
~~a.~~b. Spell out abbreviations that are not previously spelled out in the file.

11. Finalizing the Document

a. Spacing issues:

i. Align each indented listing with the previous listing to keep consistency in the document (Reference spacing above).
ii. If you are having issues with spacing at the bottom of a page, such as too much space above the Footer, try the following:

- Highlight the area
- Right Click
- Select Paragraph
- Uncheck Window/orphan control option

ATTACHMENT:
None

REFERENCE:
None

Revised: 11/09/27, 13/09/24, 15/07/14 (Year/Month/Day)
Original adoption: 10/12/03

MEDICAL RECORDS INFORMATION: CONFIDENTIALITY AND RELEASE

POLICY:

1. Health Information Services (HIS) shall process all requests for release of health record information that conform to confidentiality rules.

2. Procedures for release of health record information shall comply with federal, state and local regulatory requirements.

PURPOSE:

To protect the confidentiality of patient/resident medical records.

PROCEDURE:

1. All employees must comply with the Health Insurance portability and Accountability Act (HIPAA) Privacy rules as well as Department of Public Health (DPH) rules and regulations pertaining to resident confidentiality (see “References”).

2. A patient's/resident’s original medical record may not leave Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) except by Court Order or subpoena.

3. Health care providers may use Protected Health Information (PHI) for treatment, payment and health care operations without the individual residents’ authorization. Other uses and disclosures of PHI generally require the written authorization of the individual resident, surrogate decision maker, or conservator.

4. For medical records containing protected mental health and substance abuse information, the psychiatrist and/or psychologist must be contacted prior to release of information for authorization, unless otherwise indicated that ~~-~~an authorization is not required.

5. The properly completed authorization for release of patient medical record information includes all of the information outlined in Appendix A.

   ~~a.~~ This authorization for release of information is valid until fulfilled by HIS~~for thirty (30) days from the date it was signed.~~

   ~~b.~~a. Authorized individuals/agencies may only receive the specific information necessary to fulfill the purpose of authorization. Authorizations stating "any and all information..." are rejected. Non-essential information may not be released.

c.b. The signed authorization is filed in the medical record file. The notation of the information released, the date of release, and the signature of the staff person who released the information is noted in the Release of Information Module log kept in Health Information Services.

6. Authorization is waived when the information is:

   a. Required by law (subpoena).

   b. Requested by another health care provider currently involved in the resident's/patient's care.

   c. For medical care evaluation or records audit by a legally empowered government agency.

   The notation of the information released, the date of release, and the staff person who released the information is noted in the Release of Information Module log kept in Health Information Services.

7. Health records may be made available to researchers according to LHHPP 29-07 "Human Subject Research", which includes oversight and facilitation of written authorization from the Medical Director through the Research Oversight Committee.
   a. Researchers may not photocopy patient medical records without the Medical Director's approval.
   b. Educational studies approved through the Laguna Honda Data Governance committee to utilize data obtained from health records must not identify the subject patient, directly or implicitly, without prior written authorization of the patient and/or his/her legal guardian, and the Medical Director.

ATTACHMENT:
Appendix A: SFDPH Required Elements of An Authorization to Release Protected Health Information Form

REFERENCE:
LHHPP 21-02 Transmission Of Confidential Medical Information Via Facsimile (FAX)
LHHPP 21-04 HIPAA Compliance
LHHPP 24-08 Off Campus Appointments Or Activities
LHHPP 29-07 Human Subjects Research
DPH Policy: HIPAA Compliance – Authorization for Use and Disclosure of Protected Health Information Services Policies and Procedures 13.1 through 13.11
CHA Consent Manual

Revised: 92/05/20, 09/02/10, 11/11/29, 13/01/29, 13/09/24, 15/037/214 (Year/Month/Day)
Original adoption: 88/01/22

Appendix A:

San Francisco Department of Public Health

REQUIRED ELEMENTS OF AN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FORM

Authorization forms may not be combined with any other document (e.g., consent for treatment forms) to create a "compound authorization." The authorization form must be must be on 8 ½ x 11-inch paper and the font size must be at least 14 points.

HIPAA, state law, and DPH policy require that each patient's authorization include certain core elements as follows:

1. Patient/Client's name and date of birth
2. Name of the disclosing entity/facility
3. Name and address of the facility/individual to receive the protected health information
4. Description of the information to be disclosed
5. Description of the purpose of the disclosure
6. Expiration date or the condition upon which authorization is terminated
7. The patient or client's initials next to the types of PHI being released in a "protected classes" section for release of:
    a. mental health information,
    b. substance abuse information,
    c. HIV/AIDS information,
    d. developmental disabilities,
    e. sexually transmitted disease information.
8. Completed statements where client/patient acknowledges the following:
    a. I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization.
    b. I understand that I may not be denied treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
    c. I understand that I have a right to receive a copy of this authorization.
    d. I understand that my authorization to use or disclose protected health information expires on _____ or until _____ condition is met.
    e. I understand that I may cancel my authorization at any earlier time by writing a note of cancellation and giving it to _____. I also understand that when I give or cancel my authorization, it is effective from that date forward, and not retroactively.
    f. I understand that information disclosed as a result of this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law.
9. Signatures and Dates
    a. Patient/Client
    b. Parent/Guardian/Conservator if patient/client is unable to sign
    c. Witness, if patient/client is unable to sign

Extracted from DPH Policy: HIPAA Compliance – Authorization for Use and Disclosure of Protected Health Information, Attachment B (Date Adopted: 04/2003 Reviewed/Revised ~~02-24-10~~09-23-13)

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 use whenever the 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 LHHPP 24-08 Off Campus Appointments or Activities.)

PROCEDURE:

[Replace "chart" w/ "medical record".]

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 medical record must be handed to a staff person receiving the chart medical record 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 medical record 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 and HIS department staff 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, 15/057/0814 (Year/Month/Day)

Original adoption: 11/09/27

HANDLING MISFILED LCR ELECTRONIC HEALTH RECORDS REPORTS/NOTES[JL1]

POLICY:

The patient's/resident's medical records must contain accurate information related to the patient's/resident's condition, treatment and services received and the patient's/ resident's progress and response to treatment and services.

PURPOSE:

To implement a systematic process for handling electronic health record (EHR) errors initiated or entered by clinical staff into the Electronic Health Record (EHR) (i.e. Lifetime Clinical Record (LCR), electronic Cinical Works (eCW), and Avatar). .

PROCEDURE:

1. Whoever notices that an LCR electronic record/ note Report/Note has been filed entered in an incorrect patient/resident record shall complete an Unusual Occurrence (UO) report and provide the following information:
   a. Date and report type, e.g., "LHH-Neuropsychology note dated 7/8/11";
   b. Name and MRN of incorrect patient record;
   c. Name and MRN of correct patient record (if known).

2. Quality Management (QM) staff will route the UO for expedited review to the Health Information Service (HIS) designee, and notify the Information Services (IS) designee.

3. A clinician may contact HIS staff independent of QM's processing of UOs.

4. Laguna Honda QM staff shall notify SFGH Risk Management staff if the error originated at SFGH.

5. HIS staff will confirm the error and request, IS staff to remove the erroneous note and place the note into the correct patient record (if possible).

6. 5. If the note has been electronically signed and locked, it cannot be altered in any way, therefore an addendum note must be written to disregard the above erroneous note.

6.7. Laguna Honda HIS staff shall contact sult with other DPH Medical Record Directors orHIS Directors/Managers if needed to resolve EHRLCR Report/Note errors, originating or impacting other DPH entities.

7.8. IS staff will then delete the erroneous note from the incorrect patient's/resident's record and place the correct note into the correct patient record (if possible).

8.9. IS staff will notify QM, HIS and the clinician when Procedure 87 is completed.

~~9.~~10. QM staff will provide a monthly report to ~~the Chair of~~ the ~~Medical Record~~Health Information System Committee ~~and HIS designee~~ the status of EHR ~~LCR report/note~~ errors.

ATTACHMENT:

None

REFERENCE:

None

Revised: 15/0~~5~~7/~~08~~14~~N/A~~ (Year/Month/Day)
Original adoption: 12/07/31

RESIDENT ALCOHOL CONSUMPTION

POLICY:

1. The use of alcoholic beverages by ~~residents admitted to~~ Laguna Honda residents requires ~~by~~ a physician order~~,~~. ~~and to the extent that such use does not jeopardize the health and safety of the resident or others.~~

2. No alcoholic beverages are allowed at a Laguna Honda-sponsored resident event except with the expressed permission of the Executive staff.

PURPOSE:

To assure safe consumption ~~and access~~ of alcohol for Laguna Honda residents, balancing residents' rights with the potential of unwelcomed behaviors and injuries related to alcohol use.

PROCEDURE:

1. On admission, the resident will be informed of Laguna Honda's Resident Alcohol Consumption policy by Admissions and Eligibility Department staff and staff will request that the resident signs that s/he has received it and that by signing the document, the resident or the resident's legal representative affirms that s/he understands and agrees to abide by the policy and procedure.

2. ~~The resident's physician may write medical orders allowing a resident to have alcohol after the physician has confirmed that the resident's use is not contra-indicated.~~The resident's physician may write orders allowing a resident to have alcohol after the physician has confirmed that the resident's use is not contraindicated. This should be addressed in the resident's care plan and documented by the physician.

3. ~~Resident Care Planning related to alcohol use is indicated when the resident~~The attending physician is responsible for discussing the possible effects of alcohol use with the resident, family and staff if necessary.~~,~~

   ~~a. has a diagnosis of active alcohol abuse or history of dependency;~~
   ~~b. continues to use alcohol at Laguna Honda, whether or not the alcohol use results in aggressive or disruptive behavior; and~~
   ~~c. does not have a physician recommendation for alcohol but is requesting its use or is using it.~~

4. ~~The attending physician is responsible for discussing the possible effects of alcohol use with the resident, family and staff if necessary.~~Resident Care Planning related to alcohol use and referral for Substance Abuse Treatment services is indicated when the resident;

a. has a diagnosis of active alcohol ~~ab~~use or history of dependency;

b. continues to use alcohol at Laguna Honda, whether or not the alcohol use results in aggressive or disruptive behavior.

5. ~~Resident problems related to alcohol will~~ Unapproved use of alcohol by residents shall be reported by the observing party to the nurse manager or charge nurse who will complete an Unusual Occurrence report. Security may be called for assistance and the RCT may refer the resident ~~to or~~ for ~~receive consult from the substance~~ Substance A~~a~~buse T~~t~~treatment ~~counselor~~Services.

6. Resident specific alcohol shall be stored in medication room.

7. Before any alcoholic beverage is served at a Laguna Honda-sponsored resident event, the organizer must secure the expressed permission from Executive staff.

REFERENCE:
LHHPP 22-10 Management of Resident Aggression
LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession / Use by Residents or Visitors

Revised: 92/05/20, 00/04/27, 11/11/29, 15/07/14 (Year/Month/Day)
Original adoption: 91/06/01

HANDLING RESIDENT'S PROPERTY AND PREVENTION OF THEFT AND LOSS

POLICY:

There will be a method of accounting for and safeguarding resident's property while the resident is at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) and until the property is safely returned to the resident or legally authorized person.

PURPOSE:

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

PROCEDURES:

1. General Guidelines

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

b. The completed IRP shall be signed by the resident or the resident's representative, and by a staff member on behalf of Laguna Honda. If the resident is unable to sign, the resident will mark an "X" with two witnesses signing. If the resident is unable to mark an "X" then the nurse will write, "resident unable to sign" with two witnesses signing. If the resident understands and can express consent, the nurse will write, "resident expresses consent" with two witnesses signing. If the resident is unable to participate in the process i.e., because of cognitive deficits, the legal representative will sign on behalf of the resident with one witness signing. If the resident does not have a legal representative present, the nursing staff will note that the "resident is unable to participate in the inventory process and there is no legal representative present" with two witnesses signing.

c. A copy of the IRP shall be provided to the resident or the person acting on the resident's behalf. Thereafter, a copy of a current inventory shall be made available upon request to the resident, responsible party or other authorized representative.

d. A unit staff member will instruct the resident and his/her legal representative to leave valuables at home or send them home with family or friends. If the resident decides to keep the valuables with him/her and not in Laguna Honda's safe, the

resident may do so after signing the "Acknowledgment and Waiver" on the IRP, releasing Laguna Honda from liability for loss or damage.

e. Laguna Honda reserves the right to exclude property on the unit (such as perishables, firearm/weapons, hazardous waste, toxics, and other property that endangers the safety and welfare of other residents and staff). The IRP shall be kept in the resident's medical record. Staff shall notify the Sheriff Department at Laguna Honda (ext. 4-2319) of the resident's firearms or other dangerous weapons, and will document the disposition of the items in the resident's IRP.

f. The Admission and Eligibility Staff and/or the unit nurse will notify the resident, on or before admission to Laguna Honda, on the amount of belongings that Laguna Honda can accommodate. The resident's property must fit into the bedside table and a wardrobe.

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

h. Upon request by the resident or authorized representative, resident's valuables, which are kept by Laguna Honda in the secured area of the A&E Office shall be given to the resident or authorized representative when proper identification is provided and in exchange for the resident's or authorized representative's signature on the same receipt originally provided by the A&E Office and maintained in resident's medical record. The receipt shall be re-filed in the resident's medical record and the item deleted from the original IRP in the resident's medical record and on the IRP copy filed with the A&E Office.

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

j. ~~Friends or relatives who ask to take property home will sign a designated space on the second page of the property sheet (Form No." MR 311 b). Resident will cosign with his/ her initials.~~Items listed on the IRP may be removed only upon written consent on the IRP by the resident or the surrogate decision maker.

k. Subsequent items brought into or removed from the facility shall be added to or deleted from the property sheet inventory by a staff member on a form entitled, "Supplemental Clothing/Personal Belongings Inventory." Laguna Honda shall not be liable for property that has not been included in the IRP or for property that has been deleted from the IRP. Personal property not subject to addition or deletion from the IRP because of frequent delivery and/or removal from Laguna Honda, such as personal clothing or laundry, need not be listed, and such status

of those properties will be noted on the IRP. Friends or relatives who are asked to take property home will sign in the designated space on the second page of the property sheet (Form No. MR 311 b). Resident will cosign with his/her initials.

l. Nursing staff will ask the resident and/or the resident's representative to label or mark all of the resident's property listed on the IRP. Property shall be marked with an indelible ink pen, identifying the resident's name. The resident and/or the resident's representative also will be required to permanently tag personal items (such as prosthetic devices and small appliances). If the resident does not have a representative and is unable to mark his/her property, a nursing staff member will assist him/her in marking the property.

m. Resident dentures shall be engraved by dental services for identification purposes. ~~A staff member will recommend to the resident or his representative that the resident's dentures are engraved by the dentist or that Laguna Honda's dental clinic can provide those services.~~

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

n. ~~razor, watch, personal wheelchair or television set, and serial number of wheelchairs or television sets, when describing jewelry, document the color of the metal and stones i.e., "one yellow metal ring with clear glass stone. Do not guess at the nature of the metal, i.e., gold color metal vs. pure gold.~~

o. Do not send soiled clothing to the main laundry with hospital bed sheets and other hospital linens. Place resident's soiled personal clothing in the clothing hamper near the unit washing machine. Clean clothing is stored in the resident's individual space, such as a wardrobe locker/closet or bedside stand. If the resident's clothing is damaged or unable to be adequately cleaned, or needs to be disposed, consult with the resident. If disposal of property is then agreed upon, document the disposal and the basis for doing and update the IRP, with the staff and resident's initials.

2. Resident's Property on Relocation

a. Nursing staff will assist the resident in collecting his/her property before the resident relocates. The resident's bedside stand and locker room will be checked for properties belonging to the resident. The IRP will be updated to reflect any property that is no longer present or new property. Nursing staff will review the IRP with the resident and the resident and nursing staff will sign Form MR 311 b, indicating that the property is relocating with the resident to the new unit, with the

date. If valuables are found that exceed a value of $50, resident will be reminded to store them in the secure area at the A&E office. An attendant leaves the unit with the resident and the resident's property to the receiving unit. The sending unit nurse documents that the property has been received, and signs the property sheet, acknowledging receipt.

3. Resident's Property on Transfer and Discharge

a. Nursing staff will assist the resident with gathering the resident's property from the resident's bedside stand and wardrobe. Any of the resident monies from the unit safe will be returned to the resident.

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

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

~~representative and staff will sign off, signifying restoration of the property to the resident or his/her legal representative.~~

d. Valuables not taken by the resident upon discharge will be listed by nursing staff on the IRP and the property will be~~,~~ placed in an envelope labeled with the resident's name, unit, medical record number, contents and date of discharge and brought to Admissions and Eligibility office, Monday through Friday from 7:30 A.M. -4:00 P.M.

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

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

Note: If AWOL or AMA, refer to LHHPP 20-01 Admission to Laguna Honda and

Relocation ~~Between~~between Laguna Honda SNF Units

4. Residents Returning From Out On Pass

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

5. Reporting Stolen or Lost Property

a. Staff will complete an Unusual Occurrence (UO) Report for claims of stolen or lost property.

For lost and stolen property with a value of twenty-five dollars ($25) or more, the unit staff notified of the loss will complete an on-line ~~form LHHPP 96-06~~ UO Report and include the following information: (1) a description of the article (2) its estimated value (3) the date and time the theft or loss was discovered (4) if determinable, the date and time the loss or theft occurred, and (5) the action(s) taken~~.~~ Quality Management staff will maintain a documented theft and loss record for the past 12 months. The record ~~which~~ shall be made available to the State Department of Health Services, the county health department, or law enforcement agencies and to the office of the State Long-Term Care Ombudsman when requested. ~~in response to a specific complaint, which will contain documentation on (1) a description of the article (2) Its estimated value (3) The date and time the theft or loss was discovered (4) If determinable, the date and time the loss or theft occurred (5) The action taken.~~

b. When staff has reason to believe that a resident property with a current value of one hundred dollars ($100) or more has been stolen, they will report the loss to the Sheriff Department at Laguna Honda within 24 hours. Quality Management will maintain copies of reports to the Sheriff Department for the preceding 12 months, which shall be made available to the State Department of Health Services and law enforcement agencies, when requested~~.~~

c. The Quality Management staff will document, at least semiannually (reporting periods: January 1 through June 30 and July 1 through December 31) Laguna Honda's efforts to control theft and loss, including the review of theft and loss documentation and investigation procedures, results of the investigation by the administrator and the ~~resident~~ Resident ~~council~~ Council (if any).

d. A representative of the Sheriff Department at Laguna Honda will provide orientation of this policy and procedure to all Laguna Honda employees within 90 days of employment.

6. Notification and Reporting

a. Admissions and Eligibility staff will notify current residents and all residents upon admission, of Laguna Honda's policies and procedures relating to Laguna Honda's theft and loss prevention program.

b. A copy of Laguna Honda's theft and investigative procedures are posted in each unit.

c. A copy of California Health and Safety Code Sections 1289.4~~3~~, 1289.~~3~~4 and 1289.5 are provided to all of the residents and their responsible parties and available upon request to all of Laguna Honda's prospective residents and their responsible parties.

7. Claims and Liability

a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco" The filing of a claim form does not guarantee reimbursement for the lost or stolen property.

~~a. see http://www.sfgov.org/site/cityattorney_ index.asp?id=460.~~

~~The filing of a claim form does not guarantee reimbursement for the lost or stolen property.~~

b. Laguna Honda is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of Laguna Honda or its employee is shown. Laguna Honda may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.[DS1]~~Laguna Honda shall not be responsible for any damage, loss, or theft where, Laguna Honda has made reasonable efforts to safeguard the resident's property or if the property in question was valued at $25.00 or more and was not listed in the resident's IRP.~~

~~Laguna Honda has made reasonable efforts to safeguard the resident's property and if the property in question was valued at $25.00 or more yet was not listed in the resident's IRP.~~

ATTACHMENT:
None

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda and Relocation between Laguna Honda SNF Units
LHHPP 75-07 Theft and Lost Property Reports
"Claim Against the City and County of San Francisco" CityAttorneyFORM2 (rev. 2/01), http://www.sfgov.org/site/cityattorney_ index.asp?id=460

Revised: 06/04/03, 12/09/25, 15/07/14 (Year/Month/Day)
Original adoption: 92/05/20

GUIDELINES FOR HANDLING DECEDENTS AND USE OF MORGUE CARING FOR THE DECEASED, USE OF MORGUE, AND PROVISION OF DEATH CERTIFICATES

POLICIES:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) will maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the SFGH Morgue. or the Medical Examiner Morgue.

2.1. Nursing and Admitting & Eligibility (A&E) and Nursing Departments will collaborate to release and transfer decedents in a timely and appropriate manner.

PURPOSE:

To assist the family or legal representative with the decedent's final arrangements while maintaining respect for the decedent.

PROCEDURES:

1. Guidelines for the Notification of Families / Guardians of a Resident's Death

a. Notification of Death	Responsible Party
Family / Guardian	RCT — Nursing or Medical Staff or Social Services Physician who pronounced death
Mortuary	Family or Legal Guardian, Nurse, or A&E staff, Nursing

b. Funeral Arrangements	Responsible Party
Routine	Family or Legal Guardian
Public Administrator / Medical Examiner	A&E

2. Guidelines for the Completion of the Required Forms

a. Documentation	Responsible Party
Death Certificate	Medical Staff
Release Form	Completed by Mortician / Public Administrator A

Deceased Resident's	A&E (Monday-Friday 8a.m. - 5 p.m.)
Registry book	Nursing Office (M-Su p.m. and weekends Monday –Friday 5:001pm-87:0059am, Weekends and Holidays))
Transfer Authorization Form	Mortician

3. Releasing Remains to Morticians

a. During regular business hours (8AM-4PM, M-F), A & E staff are responsible for obtaining release from the family or conservator and/or examiner's office to authorize release of the body; and the mortuary to complete the death registry entry by writing the date, time of pick up, name of mortuary and name of mortuary attendant.

b. Evenings (after 4PM) , weekends and holidays, nursing staff are responsible for obtaining release and assuring death registry is completed. Release forms received by the nursing office will be placed in the death registry and forwarded to A&E for filing.

c. A & E retains a copy of the release form in the resident's A&E file.

d. Mortician signs in, writing date and time in Laguna Honda Death Registry book.

e. Mortician places the Release Form (from a family member or from Laguna Honda A&E) into the Laguna Honda Death Registry book.

f. Release of deceased requires a Release Form (see Procedure 3b) even if the Death Certificate must wait for physician signature.

g. Mortician must present Transfer Authorization Form at time of release of body.

h. The A&E or Nursing staff receiving the Transfer Authorization Form will sign the form and submit to A&E for filing.

4. Death Certificate

a. Health Information Services (HIS) transfers the death certificate into the EDRS (California Electronic Death Registry) to the mortuary or vice versa. HIS contacts the physician to obtain the signature on the death certificate and retains a copy of the death certificate on file. A&E presents the original Death Certificate to the mortician and retains a copy for A&E files.

b. If the resident expires over the a weekend, in the evening hours or holidays (between the hours of 5 p.m. Friday and 8 a.m. Monday):

- Signing the Death Certificate must wait until the care unit attending physician/designee is available.
- Under exceptional circumstance, if the family of the deceased or legal representative or mortician insists on immediately receiving the Death Certificate, the on call house night/weekend physician may sign the Death Certificate using his/her own signature and printed name and California Medical License #, but the on call the house night/weekend physician must print or type the care unit attending physician's name in the appropriate signature block.

5. Morgue Monitoring

a. The Morgue data base is monitored and updated by nursing and A&E.

b. A & E checks the morgue database monthly to determine whose remains have been picked up and those decedents who remain in the morgue.

c. A & E will notify the C.N.O. and the Director of Social Services if the morgue is nearing capacity (16 decedents). If the decision is made to transfer decedents, the following procedures will be implemented:

i. Request transfer of the decedent(s) to SFGH Morgue or Medical Examiner Morgue.

ii. Fax a Face Sheet to the transport service. Retain evidence of successful fax.

iii. During normal business hours A & E will arrange transport of decedent(s) to SFGH or Medical Examiner morgue.

iv. At all other times (evenings, weekends and holidays) the Nursing Office will arrange transport to SFGH or Medical Examiner morgues.

~~3. Releasing Remains to Morticians~~

~~a. Mortician signs in, writing date and time in Laguna Honda Death Registry book.~~

~~b. Mortician places the Release Form (from a family member or from Laguna Honda A&E) into the Laguna Honda Death Registry book.~~

~~c. A&E presents the original Death Certificate to the mortician and retains a copy for A&E files.~~

~~d. If the resident expired over a weekend (between the hours of 5 p.m. Friday and 8 a.m. Monday):~~

~~i. Signing the Death Certificate must wait until the care unit attending physician is available.~~

~~ii. Under exceptional circumstance, if the family of the deceased or legal representative or mortician insists on immediately receiving the Death Certificate, the house night/weekend physician may sign the Death Certificate using his/her own signature and printed name and California Medical License #, but the house night/weekend physician must print or type the care unit attending physician's name in the appropriate signature block.~~

~~iii. Release of deceased requires a Release Form (see Section III sentence 2) even if the Death Certificate must wait for physician signature.~~

~~4. Morgue Monitoring~~

~~a. Nursing Office checks morgue capacity on a daily basis.~~

~~b. If more than nine decedents in morgue:~~

~~Action~~	~~Responsible Party~~
~~Contact Admissions to arrange transport of decedents to SFGH Morgue first, then to Medical Examiner as-needed.~~	~~Admissions (M-F 8 a.m. - 5 p.m.)~~ ~~Nursing Office (M-Su p.m. and weekends)~~

~~c. Transport Options~~

~~i. Call the following transport services in the order listed:~~

~~College Chapel Mortuary~~	~~415-824-1313~~
~~Pacific Internment~~	~~415-431-9940~~
~~Medical Examiner's Office~~	~~415-553-1684~~

~~ii. Request transfer of the decadent to SFGH Morgue or Medical Examiner Morgue.~~

~~iii. Fax a Face Sheet to the transport service. Retain evidence of successful fax.~~

~~iv. Mortician must present Transfer Authorization Form at time of release of body.~~

~~v. Whoever (A&E or Nursing) receives the Transfer Authorization Form signs it~~

and retains a copy for A&E files.

REFERENCES:

NoneMSPPC01-01 Patient Expiration
NPP D8.0 Post Mortem Care
LHHPP 24-11 Notification of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death

Most recent review: 2015/07/14 10/08/24 (Year/Month/Day)
Revised: 2003/05/08
Original adoption: 2003/05/08

ACCOMMODATION OF THE FAMILY AFTER PATIENT'S DEATH

POLICY:

1. Laguna Honda Hospital's acute care units shall provide a "reasonably brief period of time" for family or next of kin to gather at the patient's bedside after a patient is pronounced dead as described in Health and Safety Code Section 1254.4.

~~2. This policy shall be provided to the family or next of kin upon request.~~

PURPOSE:

~~1. To accommodate the patient's or family's religious and/or cultural practices or concerns.~~

~~2.~~ To comply with ~~Assembly Bill 2565 and~~ the Health and Safety Code Section 1254.4.

PROCEDURE:

1. Ventilator support is not available at Laguna Honda Hospital. Therefore, the accommodation for family or next of kin related to declaration of brain death, as described in Health and Safety Code Section 1254.4, is not applicable. ~~The only form of cardiopulmonary support provided at Laguna Honda Hospital by the facility is cardio-pulmonary resuscitation (CPR)~~.

2. This policy shall be provided to the family or next of kin upon request.

~~1. As the only form of cardiopulmonary support provided at Laguna Honda Hospital by the facility is CPR, the accommodation for family or next of kin related to declaration of brain death, as described in Health and Safety Code Section 1254.4, is not applicable to patient death circumstances at Laguna Honda.~~

ATTACHMENT:

None

REFERENCE:

~~Assembly Bill 2565~~
Health and Safety Code Section 1254.4
http://www.weblaws.org/california/codes/ca_health_and_safety_section_1254.4

Revised: ~~N/A~~ 15/07/14 (Year/Month/Day)
Original adoption: 12/03/27

PASRR

POLICY:

Residents who are newly admitted from any healthcare facility, or admitted and re-admitted from the community to Laguna Honda shall have a Pre-Admission Screening and Resident Review (PASRR) assessment completed on the day of admission or prior to admission..

PURPOSE:

1. To screen and identify residents who may have a diagnosis of mental illness (MI) and/or mental retardation (MR), and to refer these residents to the Department of Mental Health (DMH), and/or Department of Developmental Services (DDS).

2. To partner and coordinate the assessment review process with State programs and ensure that individuals with mental illness and mental retardation receive the care and services they need in the most appropriate setting.

BACKGROUND:

Federal laws governing Nursing Facilities (NFs) require completion of PASRR for all residents initially entering NFs to determine if they are Mentally Ill or Mentally Retarded. If a resident is found to have MI or MR, the PASRR helps determine whether NF care is appropriate or whether resident needs specialized services.

PROCEDURE:

1. Completion of PASRR

a. Upon resident ~~The~~admission, the Utilization Management (UM) Nurse completes the revised PASRR Level 1 DHCS Form 6170 ~~evaluation form~~ via ~~PASRR - SFGetCare.~~ DHCS' PASRR web-based system.

~~a.~~ The web-based system generates a "No Need Letter" if the resident does not need referral to DMH or DDS.

~~b. If the PASRR came with the resident, the UM Nurse verifies accuracy and revises the PASRR as needed. The UM Nurse enters the PASRR in PASRR – SFGetCare.~~

~~c. When a resident who was discharged as Missing Cognitively Impaired (MCI) or Absent Without Leave (AWOL) is re-admitted during the weekend and/or holiday, the Charge Nurse notifies the Operations Nurse Manager about the re-admission.~~

The Operations Nurse Manager or designee completes the PASRR DHCS 6170 form (refer to the form posted under LHHPP 96-14 Form or Appendix A or under Laguna Honda forms in the Intranet) for a re-admitted resident on the weekend and or holiday from AWOL or MCI incident. The PASRR form should be completed during the day/shift the resident was re-admitted. The Operations Nurse Manager or designee sends the completed form of the PASRR to UM Department via the QM in-box in the Nursing office.

Upon receipt, the UM Nurse reviews the PASRR and verifies for accuracy. If the PASRR requires an update, the UM Nurse will complete a new PASRR and enter the information in PASRR - SFGetCare.

d.b. The UM Nurse/designee submits original copy sends the printout of the PASRR Level 1 and the Notice of No Need Letter to Health Information Services (HIS) for filing and attaches a copy to the Treatment Authorization Request (TAR) and UM Department case files.

e. HIS staff files PASRR in resident's medical record.

f.c. The Medical Social Worker (MSW) includes information from PASRR for Minimum Data Set (MDS) coding, and MR705.

2. Completion of Level II referral to DMH

a. If DMH referral is required, the UM Nurse will:
   i. Submit original to HIS
   ii. Mail referral to DMH within five working days
   iii. Attach a copy to the TAR and case file

a. The PASRR web based system determines if DMH referral is required and automatically sends the referral to DMH. The system also generates a Notice of Need Letter.

b. The UM Nurse sends a printout to Social Services of the Notice of Need Letter in an envelope addressed to the resident. The MSW shall give the Notice of Need Letter to the resident.

b.c. UM Designee logs the PASRR referral and files a copy

c.d. DMH Contractor will contact the UM Nurse Manager to confirm that the resident is still in-house prior to assigning a psychologist or psychiatrist to conduct the DMH Level II Evaluation.

d.e. The assigned psychologist or psychiatrist will contact the neighborhood staff or the UM Nurse Manager or designee who will inform the neighborhood

nurse when the psychologist/psychiatrist will come on-site to conduct the evaluation.

3. Completion of Level II referral to DDS

~~a. If DDS referral is required, the UM Nurse will:~~
~~i. Submit original to HIS~~
~~ii. Fax referral to DDS within five working days~~
~~iii. Attach a copy to the TAR and case files~~

a. The web based system determines if DDS referral is required and automatically generates a Notice of Need Letter.

b. The UM Nurse sends a printout to Social Services of the Notice of Need Letter in an envelope addressed to the resident. MSW shall give the Notice of Need Letter to the resident.

~~b.~~c. The UM Nurse Manager or Designee will update PASRR – SFGetCare of the referral

~~c.~~d. The UM Designee logs the PASRR referral and files a copy

~~d.~~e. They Golden Gate Regional Center (GGRC) representative conducts Level II evaluation and sends report to UM Department.

4. Review by the Resident Care Team (RCT)

a. If there is a significant change of condition, the MDS coordinator notifies UM Department via email.

~~b.~~ The UM Nurse completes status change via DHCS' PASRR web based system ~~at PASRR – SFGetCare~~

~~c. If DMH referral is required, UM Nurse will complete a Level II referral to DMH.~~

b. ~~If DDS referral is required, UM Nurse will complete a Level II referral to DDS.~~

c. The web-based system generates a "No Need Letter" if the resident does not need referral to DMH or DDS.

d. The UM Nurse sends the printout of the PASRR Level 1 and the Notice of No Need Letter to Health Information Services (HIS) for filing in the medical record and attaches a printout to the Treatment Authorization Request (TAR) and UM Department case files.

e. For completion of Level II Referral to DMH, refer to procedure 2

~~d.~~f. For completion of Level II Referral to DDS, refer to procedure 3

5. DMH Report

a. Upon availability of ~~receiving the DMH report~~ Level II Determination Letter from the web based system, the UM Nurse shall print the report and the UM designee shall:~~will:~~

   i. Log the~~DMH~~ report
   ~~ii. Upload scanned DMH report at PASRR - SFGetCare~~
   ~~iii.~~ii. Send the ~~DMH~~ report to HIS, Social Services and MD (routes to Psychiatry Services)
   ~~iv.~~iii. Send one copy to County Mental Health
   ~~v.~~iv. Attach one copy to TAR
   v. File one copy in the UM DMH binder

   ~~vi.~~ Note: The DH no longer completes 1-page Categorical or Attempted Letter. The UM Nurse attaches to the TAR a screen shot of the resolution from web-based system.

b. If the Level II ~~Report~~ Determination Letter is not ~~received~~ available in the web based system in 14 days ~~in 90 days~~ following evaluation, the UM Nurse Manager or designee shall ~~will~~ follow-up and contact DMH.

c. MSW initiates Level II discussion with RCT to review recommendations, revises the plan of care and discharge plan as needed or otherwise addresses recommendations that are not implemented in the medical record.

6. DDS Report

a. Upon receiving the GGRC report, the UM Nurse Manager or designee shall: ~~will:~~

   i. Log GGRC report
   ii. Upload scanned DDS report at PASRR - SFGetcare
   iii. Update PASRR - SFGetcare
   iv. Send report to HIS for filing in the medical records, MD and Social Services
   v. Attach one copy to TAR
   vi. File one copy in the UM DDS binder

b. If the Level II Report is not received in 90 days following evaluation, the UM Nurse Manager or designee shall ~~will~~ follow-up and contact GGRC.

c. The MSW initiates Level II discussion with RCT to review recommendations, revises the plan of care and discharge plan as needed or otherwise addresses recommendations that are not implemented in the medical record.

ATTACHMENT:

~~Appendix A: DHCS 6170 evaluation form (PASRR Level I Screening Document)~~
None

REFERENCE:

Medi-Cal Provider Manual Part 2: Billing and Policy for Long Term Care related to PASRR

Revised: ~~N/A~~15/07/14 (Year/Month/Day)
Original adoption: 11/11/29

SECURED NEIGHBORHOOD SAFETY STANDARD

POLICY:

1. ~~Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to providing a safe residential environment for all residents. For the population of residents with clinical conditions that require a secured environment to assure their well being and safety, additional procedures are implemented each shift for safe and efficient egress from the neighborhood~~.

2. Doors on the secured neighborhood (North Mezzanine) are equipped with electronic card key security mechanisms that open with a staff's card key to provide a safe and secured unit for the resident.

3. The main entrance door to the secured neighborhood is equipped with an intercom, security camera and remote door entry system (Aiphone) which allows staff to unlock the front door from either of the nursing stations for visitors without card key access, and to view if residents are near the main entrance door.

4. No earphones or other devices that may serve as distraction are permitted when entering or exiting the secured unit.

5. All staff entering and exiting the neighborhood are required to ensure that the doors are properly closed

~~3.~~6.

PURPOSE:

To describe ~~operationalize~~ and maintain safety standards for the secured neighborhood.

PROCEDURE:

1. Maintaining the Secured Environment

a. The secured neighborhood staff will check the functionality of the egress door during the Day and PM shifts. For North Mezzanine the egress will not automatically unlock without ~~a~~an electronic card key. ~~that their card keys work on each of the neighborhood exit doors when they first arrive on the unit.~~

b. The secured neighborhood staff will check the remaining non-egress exit doors during the Day and PM shifts to ensure the doors are locked.

~~a.~~c.

~~b.~~d. ~~The charge nurse will ensure that float staff check that their card keys are functional before they begin their assignment~~.

~~c.~~e. ~~The nurse manager will ensure that the secured neighborhood has extra~~

~~card keys. If staff does not bring his/her card or has a card key that does not work when tested, a neighborhood card key will be assigned to the staff for use during his/her shift and will be returned at end of shift~~.

~~d.~~f. The nurse manager/charge nurse will report card key operational problems to Facility Services during business hours for repair or replacement. ~~(M-F from 7~~ Notify Facility Services ~~AM~~ /~~8am – 3:30 PMpm; extension 4-2314). Notify~~and Sheriff's Dept. for door security issues.

~~e.~~g. ~~Facility Services Department will replace card keys that cannot be repaired~~.

~~f.~~h. In the event of ~~power failure or~~ fire alarm activation, ~~including during fire alarm testing,~~ the locking mechanisms on exit doors in the secured neighborhood automatically unlock. Staff will monitor exit doors to ensure resident safety, and evacuate residents if indicated.

~~g.~~i. In the event of power failure, fire alarm activation, one nursing staff from North 1, North 2, North 3, and North 4 will be designated to report to North Mezzanine to assist in monitoring the exits on the neighborhood.

~~h.~~j. At the beginning of each shift, the charge nurse will designate which staff member will be responsible to monitor each exit door.

2. **Use of the Intercom/~~,~~ Security Camera ~~(Aiphone®)~~ and Door Entry System ~~(Aiphone)~~**

a. There are 2 intercoms~~Aiphones~~ located in the North Mezzanine neighborhood, one at each nursing station. The intercom~~Aiphone~~ located at nursing station 1 is the master intercom~~Aiphone~~. The on/off switch is located on the left side of the handset. If the master intercom~~Aiphone~~ is turned off, both intercoms~~Aiphones~~ will be disabled. The doors will remain locked if the Aiphone is disabled – staff will manually swipe their badges to allow people to enter/exit.

b. The master intercom~~Aiphone~~ may~~can~~ be turned off as a precaution (e.g., at nighttime after visitor's hours) to avoid improper use of the key button when staff are not present at the master stations.

~~b.~~c. The intercom~~Aiphone~~ is connected to three cameras. The camera views are as follows:

i. Camera 1: Intercom - This camera's view can be adjusted (up or down) with the up/down button on the intercom~~Aiphone~~.

ii. Camera 2: Elevator lobby

iii. Camera 3: Interlock/Trap area located behind the locked door (allows staff to see if residents are standing behind the locked door)

~~c.~~d. Directions for Using the Intercom~~Aiphone~~

i. When a visitor rings the doorbell, an audible alert~~"ding-dong" noise~~ will sound and the intercom~~Aiphone~~'s camera will turn on.

ii. Pick up the handset and talk with the visitor. Only one person can talk (and be heard) at a time.

iii. Press the up/down button on the intercom ~~Aiphone~~ to move the camera 1 to better visualize the visitor.

iv. Press the monitor button to switch the camera view between cameras 1, 2 & 3. Staff will check camera 3 before allowing visitors to enter because this view allows the staff to see if residents are standing in the trap area and potentially waiting to tailgate out the door.

v. To allow the visitor to enter, press the key button to unlock the door. This will unlock the door for 5 seconds. Tell the visitor that they may now enter - the visitors will not hear any indication that the door has been unlocked.

vi. Continue to monitor the locked door until the lock re-engages.

3. Staff Education

a. Staff shall be trained upon orientation, and procedures shall be reviewed with new staff ~~assigned to the secured neighborhood~~. All staff should be reminded and educated to be attentive when entering or exiting the secured neighborhood to prevent resident elopement.

i. All staff are required to look through the window to ensure the foyer is clear before proceeding.

ii. No earphones or other devices that may serve as distraction are permitted when entering or exiting the secured unit.

iii. All staff entering and exiting the neighborhood are required to ensure that the doors are properly closed.

iv. SMART Training Principles shall be utilized if necessary.

v. Only authorized staff and visitors (with visible badge) may be permitted entry with staff entering the neighborhood.

4. **Procedures for Nutrition Service Staff Entering Secured Neighborhood**

   a. For meal deliveries, including early and late trays and special food deliveries, transporters will ring the bell, allow nursing staff to open the door, and wheel the delivery carts into the foyer (the corridor between the first and second doors).

   b. Nursing staff will wheel the food carts into the Great Room and distribute meals to the residents.

   c. After each meal, nursing staff will wheel the food carts with soiled trays back into the foyer for Nutrition Services staff to pick up.

   d. Transporters arriving to pick up the soiled trays will ring the bell, allow nursing staff to open the door, and retrieve the carts for transport back to the kitchen to be washed.

   e. In addition to delivering or retrieving trays, Nutrition Services staff will enter the secured unit to restock nourishment and supplies, clean the galley, or refill the coffee and juice dispensers. Staff members will ring the bell and be escorted into the Great Room where they will proceed with their assigned task. Staff may request an escort upon exiting the neighborhood if they choose.

5. **Performance Improvement**

   a. ~~a.~~ The licensed nurse shall complete an Unusual Occurrence report when a resident elopes from the secured neighborhood and anytime security is breached.

   b. ~~Resident elopement~~ ~~i~~Incidents will be reviewed to identify process improvement opportunities and staff training needs.

ATTACHMENT:
None

REFERENCE:
LHHPP 24-01 Elopement Response Procedure
LHHPP 24-04 Resident Found Off Grounds
LHHPP 60-04 Unusual Occurrences
Aiphone Operation Manual

Revised: 10/12/03, 11/09/27, 13/01/29, 15/07/14 (Year/Month/Day)
Original adoption: 04/02/12

DOCUMENTING/REPORTING RESIDENT ALLERGIES/ADVERSE DRUG REACTIONS~~- approved 6.16.15 NEC~~

POLICY:

Licensed nurses and other clinicians who learn of a resident's allergies and/or adverse drug reactions (e.g., medication, food, environmental, other) ~~to medications or foods~~ are responsible for ~~communicating~~reporting and documenting this information so as to ensure patient/res~~dient~~ident safety.

PURPOSE:

To communicate residents' allergies and/or adverse drug reactions.

PROCEDURE:

A. Upon admission and for the duration of the resident's stay, identified allergies ~~/~~ and/or adverse drug reactions are documented in the following places:

1. Medical Record Chart: ~~Binder:~~

   a. Place "allergy~~ic~~" tape on front of the chart and ~~write in the~~record identified ~~allergies~~allergies and/or adverse drug reactions.
   b. The physician writes allergy and/or adverse drug reactions ~~information~~ into the orders.
   ~~b.~~c. At bottom of Physician's Order Sheet print outs and TAR.
   ~~b.~~d. For new allergies, for an established resident, the physician will document the allergy in EHR~~eCW~~ and writes on the Physician's Order Sheet.

~~At bottom of Physician's Order Sheet~~
~~c..~~

2. Resident Care Plan: Write allergies and/or adverse drug reactions in **red** ink.

3. Medication Administration and Treatment Assessment Records: Record on each page.

4. Admission Nursing Assessment: On admission, state what specifically causes allergic reactions, or indicate that there are "NONE KNOWN DRUG ALLERGIES" or "NKDA".

5. Allergy Color Code Color: RED is the code for allergies. Write resident's name and ward location on a red name strip.

6. Resident Identification Band: Red band indicates allergies.

7. Allergy and/or adverse drug reactions information is also recorded in the EHR by clinicians at LH and throughout the SFDPH.

B. Residents should be observed for allergic reactions and adverse drug reactions throughout their stay.

CROSS REFERENCES:

LHHPP File: 25-04 Adverse Drug Reaction (ADR) Reporting Program

Nursing P&P B 5.0 Color Codes – Resident Identification
Nursing P&P C1.0 Admission and Readmission Procedures
Nursing P&P C 1.2 Relocation Procedures
Nursing P&P C 1.3 Discharge to Acute
Nursing P&P J 1.0 Medication Administration

Revised: 12/2004, 1/2010, 09/24/2013; ~~06/16/15~~07/14/2015

Reviewed: ~~09/242013~~ _____

Approved: ~~09/24/2013~~ _____

TRANSCRIPTION AND PROCESSING OF ORDERS[GEM1] **- for MEC approval**

POLICY:

1. 1. Licensed nurses (RN, LVN, LPT) are responsible for the review, transcription and processing of orders written on their shift. Transcription and processing of orders may be delegated to the unit clerk under the supervision of the licensed nurse. If the unit clerk transcribes and processes the order, the entry is verified and countersigned by the licensed nurse.

2. 2. In the interest of resident safety, iIncomplete, questionable or confusing orders are clarified with the prescriber and if appropriate, pharmacy, prior to implementation or processing in the interest of resident/patient safety (refer to NPP J 1.0). The Nurse Supervisor/Manager on duty should be called if the clarification has not remedied the licensed nurse's concern.

3. 3. Medication orders are accepted in electronically, in writing, and by telephone or verbal order [MI2]directly from a physicianan authorized prescriber as outlined in LHHPP 25-03 (http://in-sfghweb01/LHH/policies/Policies.htm)HWP 25-03., or through a Licensed Pharmacist (this is confusing, pharmacists that receive telephone orders must write them down, when I read this it sounds like the pharmacist can call the nurse and give the verbal order?.
4. Telephone and verbal orders are used only when absolutely necessary, "written down and then 'read back by the recipient, and confirmed or corrected by the prescriber[MI3]."' to confirm accuracy, R., r Refer to ence LHHPP 25-03 HWP 25-03 (http://in-sfghweb01/LHH/policies/Policies.htm).[refer to P&P for verbal orders]

4.The following providers are authorized to give verbal orders:
5.
   a. Physician
   b. Affiliated Health Care Practitioner credentialed by the medical staff
   c. Dentist
   d. Podiatrist
   d.

4.6. The following job classes are authorized to accept verbal orders:
   a. Licensed Nnurse (LN)
   b. Licensed Ppharmacist
   c. Licensed Rrehabilitation Ttherapist
   d. Respiratory Ttherapist
   e. Clinical Dietitian

f.
5.7. Licensed nurses (LN) and unit clerks will may write nursing order to reference electronic orders.

6.8. Each resident's orders are reviewed monthly by the physician and the licensed nurse.

7.9. 6. All residents' charts are reviewed nightly by A.M. (night-) sShift Licensed NurseLN to verify that all orders for the previous twenty four (24) hour period have been noted and processed.

PURPOSE:

1.To assure that orders are accurately and appropriately transcribed and processed.

2.To decrease risk of harm to resident, related to the transcription process or order error.

PROCEDURE:

A. Processing of Orders

1. 2. All documentation in the Physician's Order Sheets[AMH4] (POS)Interdisciplinary Progress Notes, Medication Administration
2. Record
(MAR), Treatment Administration Record (TAR), and Interdisciplinary Progress Notes Physician's Order Sheets will be recordeddone in black ink using Meridian time (24-hour clock).

2. Note the order processing by writing in red ink the date, Mmeridian time (24-hour clock) and signature following the physician's order. Electronic orders will be noted in the electronic health record (EHR).

3. Following review, and if when necessary, clarification of the order, has been completed, the licensed nurseLN or unit clerk accurately transcribes the order exactly as written to the appropriate form (e.g., MAR edication or TARreatment Administration Records).

1.The nurse or unit clerk processing the orders may add in the Code column the coding for the computer - generated forms as follows:

"D" for Diagnosis
"M" if order is to appear on the Medication Administration Record
"T" if order is to appear on the Treatment Record
"O" if order is to remain on the processed Order Sheet, e.g. Diet/ Miscellaneous
"X" for STAT orders, one-time order or time-limited order which does not go over into the next month, i.e. not to be picked up by transcription.
(The codes are not used by all nurses, but by admitting units and by RAIC.4

B. Nursing Orders

1. To initiate a nursing order record write the date, time and the phrase[MI5]"nursingphrase "nursing order" or "N.O" followed by the order and the registered nurse's legible signature and title.

2.Nursing orders may be coded to appear on the Treatment (T) or Medication (M) Administration Record.

3.2. Note and transcribe in the same way as physician orders.

C. Telephone or Verbal Orders

1. See Hospital wide Policy 25-03 for Verbal/Telephone Orders

2. For verbal order recorded electronically the licensed nurse or unit clerkar will write an order on the physician order sheet to "See eCW for Refer to electronic record."

D. Processing Orders to Pharmacy

1. E-prescription by the physician will be sent electronically by the E-H-R- to the Pharmacy.

2. Fax or delivertakeTake or fax new and discontinued medication orders to pPharmacy[AMH6].

2.3. Faox or deliver nursing orders related to medications to the pharmacy.

E. "STAT" Orders & Pharmacy Response Time

1. Nursing service and pharmacy shall process stat orders immediately during regular pharmacy hours. Outside of pharmacy hours STAT orders are obtained by Operations Nurse Manager/Supervisor refer to Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies.

2. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered "STAT" which are available in the unit emergency drug box shall be administered immediately.

3. New orders for anti-infectives and medications that are used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

4. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

F. Discontinued Medication Orders

1. By the end of shift during which the medication is discontinued, the Licensed NurseLN will send or fax the order to pPharmacy.

1.2. Refer to NPP J1.1 for Obtaining, Handling, Storing of Medications.

2.3. If the medication is discontinued electronically, the licensed nurse or unit clerk will write a nursing order on the physician order sheet referencing the discontinued medication order and will fax the nursing order to pharmacy.

3.4. Highlight in yellow the entire entry of the discontinued medication or treatment in the respective MAR or the TAR and record date of discontinuation.

G. Monthly review of computer generated Printed Physician's Order Sheets:

1. The physician reviews medication orders monthly and documents the review in the EHR.

2. Nursing staff (unit clerk or licensed nurseLN) while processing orders routinely pull the pink and yellow copies when the order sheet sf [MI7]full and place the copies in the HIS pick-up box.

3. Once a month, HIS takes a duplicate copy of the handwritten Physician's Orders (original stays in chart), to process orders not already entered into the computer. The lLicensed nNurseLN will draw a line across the blank remaining space of the single original sheet once the copies (colors) have been removed so that no further orders can be written on thatis page.

3.4. A new, blank physicians' order sheetPOS is to be inserted for writing the new orders after the copies have been pulled.

4.5. The following month's orders, medication and treatment administration recordsMAR and TAR are printed and delivered to each unit before the end of the month.

5.6. Orders written on physician order sheetPOS or in the EHR after the copies have been pulled and sent to pharmacy after HIS takes the duplicate copy may not appear on the new printouts and must be transcribed by the unit clerk or licensed nurse[MI8]LN nursehand onto the new medication and treatment sheetsMAR or TAR sheets.

6.7. Licensed nurses on all any shifts are responsible for checking transcription accuracy of newly printed physician's ordersPOS, Medication and Treatment Administration RecordsMAR, and TAR. Transcription accuracy is checked by comparing new physician orders on physician order sheetPOS, and in EHR, MAR/TAR, against last month's printed orders on the date they were noted [GEM9]and against all subsequent orders that were hand written during the month.

7.8. To correct an incorrectly printed order on the computer generated printed Physician's Orders SheetPOS, draw a single line through it and LN signs with their add your initials. Write the date and the correct order just below the incorrect order or on a blank physician's order form.

8.9. When a discontinued order appears on the computer generated printed order sheetPOS, the Licensed NurseLN will cross out, date and initial the discontinued order.

9.10. After reviewing and making corrections on the new monthly orders, Medication and Treatment Administration RecordsMAR and TAR, the reviewing licensed nurseLN signs and dates

the order sheet on the line designated "Above orders reviewed by". This means that the orders are correct and current as they appear on paper and in EHR.

10.11. In order to correct an error on the Medication or Treatment Administration Record, the licensed nurse will rewrite the entire corrected order in a new box. The entry box in error will be completely highlighted in yellow and marked with a "DC" [GEM10]and the date. The LN will submit an HIS correction form for errortserrors on the MAR/TAR and place the form in the HIS box.

11.12. When the physician reviews monthly orders and wants to discontinue an order, the D/C order is to be fully written out on the Physician order sheetPOS.

12.13. When the physician has signed the printed order sheetPOS, the licensed nurseLN signs and dates the line designated "Above orders noted by". After this review, there should be no changes to printed order sheetPOS.

13.14. On the last day of the month, the P.M. (evening shift) . The licensed nurse will remove the current medication sheets and treatment sheetsMAR and TAR from the binders and insert the new sheets. Set aside completed sheets for the HIS technician to fileinsert into the resident's chart. Documentation on new sheets will begin at 0001 (12:01 A.M.) on the first day of the month.

14. MARs/TARs: Dates on top of sheets will be adjusted to reflect the starting date/dayte of new orders. MARs will not automatically begin on the first of the month. Dates on bottom of the sheets will be the date HIS pulled the physician order sheets.

H. Use of Physician Order Processing Correction Request form (Appendix Three)

Licensed staff may use the Physician Order Processing Correction Request form to make corrections to the computer generated Physician's Orders Sheet, Medication Administration Record or Treatment Administration Record in between monthly reviews. Correction forms are to be obtained from and returned to HIS. A copy may be maintained on the unit for reference until the correction is made.

I. Nightly Verification of Order Processing and Transcription by A.M. Shift Licensed Nurse

1. Licensed Nurses will review both thethe EHR progress note and Physician Order SheetPOS for Physician's Order , MAR, and TAR of each resident for new orders in the past 24 hoursfor new orders.

2. The Licensed NurseLN verifies that each order In the Physician Order SheetPOS and EHR in the past 24 -hour period washas :

a.2. a. been noted and transcribed in the MAR/TAR, etc. .,
   a. If the order has not been noted, the A.M. nurseLN will transcribe and carry outprocess the order.
   b. been accurately processed the Physician's Order, MAR, TAR, etc.,[MI11]
   c.b. if an order has not been processed, the night licensed nurse will do so. IIf the licensed nurseLN is unable to carry out process an order, s/he will consult with the Nursing

Operations Manager/Supervisor about any necessary remedial action. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.

3. If the A.M. Licensed NurseLN discovers an error in the transcribprocessing of the order, s/he must immediately discontinue the erroneous entry on the MAR by using the "Discontinuing an Order" as per entry in E. above. Then the licensed nurseSubsequently s/he shouldLN rewrites the entry accurately per the MD order. If a medication error has been made, Operationsthe physician and Nursing Manager/Supervisor must be contacted and an Unusual Occurrence form completed. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.

4. Once the licensed nurseLN confirms that all orders have been accurately transcribed and carried outprocessed from both the EHR and the Physician's Order SheetPOS, the licensed nurseLN:

   a. For the Physician Order Sheet usess the stamp, "24 hour order check completed by_____ (signature, title) at ___(time, date)", immediately below the last order. S/he then signs and dates in red ink in the appropriate places.
   4.b. For EHR, the LN signs/notes in the EHR that the 24 hour check was completed.

ATTACHMENTS:

APPENDIX ONE: Medication documentation Examples
APPENDIX TWO: Verbal Orders for PT, OT, ST Memo
APPENDIX THREE: Form for Medical Record Services Physician Order Processing Correction Requests

CROSS REFERENCE:

NPP J 1.0 Medication Administration
NPP J 1.1 Obtaining, Handling and Storing of Medications
LHHPP File 25-02 Safe Medication Orders
LHHPP File 25-03 Verbal Telephone Medication Orders
Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies

LHHPP File 25-04 Adverse Drug Reactions Reporting Program

Revised: 8/2001, 4/2006, 12/2006, 03/2008, 8/2008, 10/2010, 02/2014, 07/14/2015

Reviewed: 07/14/2015_____

Approved: _____

For Ghe use only:
Date sent to Policy Reviewer **02/2014**
Date reviewed by CNS 02/28/14
Date reviewed by NEC _____
Date approved by NEC _____
Date routed to MEC _____
Date emailed to Karina _____

FOOT CARE

POLICY:

1. Nursing assistants~~, except for Home Health Aides~~, are ~~is~~ responsible for inspection of the resident's ~~skin~~ feet/foot daily, routine nail and toenail trimming ~~,~~ and reporting of any unusual findings to the licensed nurse~~, and disinfecting of the nail and toenail clippers with facility-approved disinfectant after each use~~.

2. The Licensed Nurse is responsible for informing the physician ~~of any unusual foot issues and~~~~for~~ of possible need for ~~recommend~~ p~~P~~odiatry referral~~ as needed~~.

   ~~3. Routine nail and toenail trimming is performed by nursing staff as needed however resident's with elongated or thickened toenails will be referred for Podiatry Services~~.

~~4.~~3. Each resident will be provided with individual nail and toenail clippers.

PURPOSE:

To describe the process for routine foot care.

PROCEDURE:

A. Routine Foot Care

i. Inspect skin condition of resident's feet, including between and under the toes to check for cuts, blisters, redness, swelling, irritation, discoloration, or any other unusual skin condition. Report any unusual findings to the Licensed Nurse.

ii. Use soap or foam cleanser to ~~gently scrub~~clean feet and toe nails.

iii. Rinse and gently dry feet, paying attention to the areas between and under the toes then apply moisturizer.

iv. Apply socks or stockings before applying shoes or before resident stands and ambulates. ~~Support resident's feet with foot rest who are unable to self-propel when in wheelchair~~.

v. Shoes should be well-fitting and non-compressive. Check the inside of the shoes to make sure that they do not have any protrusions, rough spots or bumps.

vi. When the resident is in bed,

   a. Heel protectors maybe applied as warranted.
   b. Foot cradle may be placed at the foot of the bed to prevent weight of top bedding from exerting pressure on the toes and to provide support for the feet.

B. Toenail trimming

~~a.~~i. Trim toenails straight across.
~~b.~~ii. Never cut or dig out corner of nails. Do not trim skin.
~~c.~~iii. Smooth rough edges with an emery board as needed.
~~d.~~iv. Inform L~~l~~icensed N~~n~~urse if unable to trim nails.

C. Documentation

1. Nursing Assistants will document on the DNCR for any unusual foot issues and report to the Licensed Nurse.

2. Licensed Nurse ~~will notify physician and~~ will document any skin changes and physician notification in the Integrated Progress Notes.

REFERENCES:

Lippincott, Williams, and Wilkins, Lippincott Manual of Nursing Practice, 9th Edition, 2010
Bryant, R.A. & Nix, D.P. (2012). Acute & Chronic Wounds: Current Management Concepts, 4th edition Elsevier, St. Louis, Missouri

CROSS REFERENCES:

NPP D2 2.0 Bathing Alternatives and Bed Baths
NPP D2 4.0 Operating and Cleaning Jacuzzi Tub
NPP K 2.0 Wound Management and Assessment

Revised: 8/2000; 2/2010; 07/22/2014; 07/14/2015

Reviewed: ~~07/22/2014~~ _____

Approved: ~~07/22/2014~~ _____

ARM SLING

POLICY:

1. The Licensed Nurse (LN) shall collaborate with Rehabilitation Services and Physician to determine what the type of sling is to be used. Physician will determine duration of use.

2. Any member of the nursing staff (RN, LN, CNA, or PCA) may apply a sling as ordered.

3. Each sling will be individually labeled with the resident's name.

PURPOSE:

To provide proper use and care of an arm sling.

PROCEDURE:

A. General

1. Obtain from either Occupational Therapy Department (OT) or Central Supply Room (CSR) the prescribed sling.

2. Follow rehab staff or manufacturer's instructions for proper application, use, and maintenance, including replacement, of an arm sling.

3. Perform daily skin checks and as needed.

B. Documentation

1. Licensed Nurse documents in the Interdisciplinary Progress Notes for any abnormal findings and non-adherence to treatment.

2. CNA or PCA documents use of sling in the DNCR.

REFERENCES

Sling Application: Performing. Smith, N. and Kornusky, J. authors. Cinahl information Systems, a division of EBSCO Information Services; 2013 – electronic access on March 18, 2014.

Sorrentino and Remmert, Mosby's Textbook for Nursing Assistants, 8th edition, 2012~~Sorentino, Mosby's Textbook for Nursing Assistants, 6th Edition, 2004~~

Revised: 8/2000, 2/2010, 05/27/2014; ~~06/16~~07/14/2015~~**April 24, 2015**~~

Reviewed: ~~05/27/2014;~~ _____ ~~**April 24, 2015**~~

Approved: ~~05/27/2014~~ _____

COLLECTION OF URINE SPECIMENS

POLICY:

1. The licensed nurse may obtaincollect urine specimen throughfrom midstream catch (clean-catchvoided) collection technique, intermittent, ,straight or indwelling urinary catheter as ordered by the physician.

2. The licensed nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA) is allowed tomay collect urine specimen through routine or midstream or clean-voided technique method catch.

3. The licensed nurse willmust notify the physician immediately if the specimen cannot be obtained.

1. A physician's order is required to send specimens to the laboratory.

2. Routine and midstream specimens may be collected by Licensed Nurse, Certified Nursing Assistant, (CNA), or Patient Care Assistant (PCA).

3. Specimens obtained by catheterization or from an indwelling Foley catheter are to be collected aseptically by the Licensed Nurse.

PURPOSE:

Urine specimens are collected per LHH policy and sent to the lab to determine infection or other pathological conditionsTo describe guidelines forto the nurses when collecting urine specimen. .

PROCEDURE:

A. Equipment for Urine Collection

Obtain the following from Neighborhood Supply if not prepackaged kit:

Sterile screw-cap specimen container
Clean plastic bag
Antiseptic Towelette
20 ml syringe with Luer- Lok tip (for catheter drain bag with needleless sampling port)
(As needed) Urethral catheterization tray
Requisition forms:
Urine/Fluids: Requisition for Urinalysis or other physician's order urine tests
Microbiology: Requisition for Cultures
Label

B. Laboratory Requirements

1. All urine specimen containers must bes are to be labeled with date and time collected with, stamped laboratory addressograph including, containing resident name, laboratory ID number, neighborhood, and bed number prior to collection of the specimen.

2. Licensed Nurse completes the Clinical laboratory requisitions must bewith stamped with the laboratory addressograph and writes the method of specimen collection, date and time. Verify and completed accurately, including the physician's ID number, applicable pager number, and ICD

-109 codes, collector's name and pertinent medical diagnosis, and medications iIndicate if STAT was ordered. Clipped or placed the laboratory requisitions in the outside pocket of the specimen plastic bag.

3. Method of urine collection must be stated on the requisition.

4.3. Licensed Nurse completes two different laboratory requisitions for urinalysis and for When collecting urine for culture and sensitivity. and urinalysis,Urine specimens are to be sent in two separate containers. with the two different laboratory requisitions.

5.4. All specimen containers must be securely tightened to avoid leakage. Depending on the type of test, some uUrine specimens may require for culture should be transportED on ice.

C. Collection ofMethods of Collecting Urine Specimens

1. Midstream (Clean-Voided) Catch Technique – refer to Attachment 1

- Urine Midstream catch (clean-catch) technique is obtaining urine after the initial flow of urine.
- Instructions for obtaining midstream catch:
  - Wash hands thoroughly and don on non-sterile gloves.
  - Sit the resident in the toilet seat.
  - Clean the periurethral area with antiseptic towelette prior to voiding.

    For Female Resident: Spread the labia with the non-dominant hand. Using the towelette, clean the urinary opening by wiping one side of the labia from front of the labia towards the rectum (front to back). Repeat the same procedure on the other side of the labia using a new towelette. Then clean the urethral opening with a new towelette.

    For Malee Resident: Retract the foreskin (if present). Clean the urinary meatus and the glans with a towelette, moving outward in a circular motion. Then repeat procedure using a new towelette.
  - Instruct the resident to begin urinating. After a strong flow of urine, place the specimen container to collect the urine about 30 – 60 ml. Allow the resident to finish voiding.
  - Avoid touching the interior surface of the specimen container or lid to avoid contamination. Close the container lid tightly and wipe the outside of the container with a new toilette.
  - Wash hands thoroughly after the procedure.
- Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

Collection
Refer to Lippincott's Nursing Procedures book for additional information.

2. ~~Collection of Urine Specimen using Straight~~Intermittent Urinary Catheter – refer to Attachment 2

   - ~~Gather necessary supplies. Provide privacy and explain the procedure and its purpose to the resident or family.~~
   - ~~Perform hand hygiene and don on non-sterile gloves.~~
   - ~~Provide good lighting.~~
   - ~~Position resident as follows:~~
     - ~~Female: Dorsal recumbent position (on back with knees flexed), have resident relax the thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip.~~
     - ~~Male: Supine position with legs extended and thighs slightly abducted.~~
   - ~~Wash the perineum with warm soapy water and rinse thoroughly. Discard gloves and perform hand hygiene.~~
   - ~~Established a sterile field nearby by the resident for easy access of the urinary catheter tray.~~
   - ~~Don on sterile gloves.~~
   - ~~Remove the supplies from the catheter tray and organize them within the sterile field.~~
   - ~~Check catheter for any defect.~~
   - ~~Maintaining a aseptic non-touch technique, clean the external orifice as follows:~~
     - ~~Female:~~
       - ~~Using the non-dominant hand, exposes the meatus by spreading the labial folds to expose the urinary meatus.~~
       - ~~Once the external urinary orifice is exposed does not allow it to close, especially after the antiseptic cleansing agent has been applied. If the labia closes after cleaning, the skin is considered contaminated and must be recleaned.~~
       - ~~Keep the non-dominant hand in this position for the remainder of the procedure – this hand is now unsterile. Asks assistant to illuminate the meatus with a penlight, if needed.~~
       - ~~Using the dominant hand, clean with antiseptic swab one side of the vulva and perineal area using one swipe technique beginning from the one side of the clitoris, cleaning along the labia majora, labia minora, and adipose tissue and ending before the perianal area. Discard the antiseptic swab.~~
       - ~~Clean the other side of the vulva and perianal area using the same technique as stated above.~~
       - ~~With a new antiseptic swab, clean the center of the vulva using the one swipe technique beginning above the clitoris, wiping directly over the urethral meatus and ending before the perianal area.~~
       - ~~Do not reuse antiseptic swabs over previously cleaned tissue.~~
     - ~~Male:~~

- ~~Using the non-dominant hand, hold the penis and gently retracts the foreskin, if applicable. Once the external urinary orifice is exposed, keeps the non-dominant hand in this position for the remainder of the procedure.~~
- ~~Using the dominant hand, apply antiseptic swab in a circular motion completely around the penis glans. Clean in a circular motion starting at the tip and working outward. Does not wash back and forth across the urethral opening.~~
- ~~Use separate sets of antiseptic swabs to complete three separate cleansing circuits.~~
- ~~Do not reuse antiseptic swabs over previously cleaned tissue.~~

~~Generously lubricates the proximal tip of the catheter.~~

~~Using the dominant hand, grasps the catheter 3–4 inches from its insertion tip and coils the remainder of the catheter in the palm, if necessary, to keep the catheter sterile.~~

~~Insertion of intermittent catheter:~~

~~Female:~~

- ~~Asks the resident to cough or bear down as the catheter is inserted.~~
- ~~Slowly advances the catheter in a slightly downward direction (to track the slight curve of the urethra) through the external urethral orifice toward the bladder, which is ~3–4 inches or until urine begins to flow.~~
- ~~Once urine appears, continues to advance the catheter an additional 1–2 inches to make certain that the catheter tip rests within the bladder.~~

~~Male:~~

- ~~Hold the penis at a 70–90° angle to the patient's legs. Gently stretches it upward to create a straight path through the penile portion of the urethra.~~
- ~~Ask the resident to bear down or cough as the catheter is inserted into the urethra.~~
- ~~Slowly advances the catheter through the external urethral orifice toward the bladder.~~
- ~~Continue to advance the catheter ~ 7–8 inches or until urine begins to flow.~~
- ~~Once urine appears, continues to advance the catheter an additional 1–2 inches to make certain that the catheter tip rests within the bladder.~~

~~Never force the catheter.~~

~~Place the distal end of the urinary catheter within the sterile basin collection tray to allow the urine to drain into the tray until the bladder is empty.~~

~~Prior to removing the catheter, rotate the catheter, if desired, to completely drain urine in dependent areas of the bladder.~~

~~Transfer the appropriate amount of urine to the sterile specimen container and attaches the lid securely.~~

~~With the dominant hand, slowly withdraw the catheter and allow it to fall into a garbage bag.~~

~~Clean the excess antiseptic and lubricant from the resident's genital area.~~

~~Assist the resident into a comfortable and safe position.~~

~~Discard all soiled materials and perform hand hygiene.~~

Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

3. Collection of Urine Specimen using Indwelling Urinary Catheter

   a. Using aseptic non-touch technique, collect the specimen from the specimen collection port in the tubing of the urinary catheter (e.g., transurethral or suprapubic), not in the urine collection bag or from the catheter tubing directly.

   b. Clean the needleless sampling port with a facility-approved antiseptic solution and allow to air dry.

   c. Clamp or fold the urinary catheter tubing distal to the collection port.

   d. Insert a luer-lok tip syringe into the port at a 90 degree angle to the tubing and slowly aspirate the urine, withdraw about 10 ml of urine.

   e. Transfer the urine sample to the sterile specimen container and attach the lid securely.

   f. Wipe the sampling port with a facility-approved antiseptic swab; allows to air dry. Then unclamp or unfold the urinary catheter tubing to permit urine to drain into the collection bag.

   g. Secure and label the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.
   Wipe the needleless aspiration port with alcohol prep and insert a luer-lok tip syringe into the port at a 90 degree angle to the tubing.
   Withdraw 10 ml of urine

2. For specimens from an indwelling Foley catheter: Wipe the needleless aspiration port with alcohol prep and insert a luer-lok tip syringe into the port at a 90 degree angle to the tubing. Withdraw 10 ml's of urine.

D. Disposition of Urine Specimens

1. For STAT order, on weekends, holidays, or after hours, the specimen is delivered to pavilion SNF and the Licensed Nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation to pick-up specimen.

2. For regular working hours, send urine specimens directly to the Clinical Laboratory by any nursing staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include urine specimen in the earliest lab courier pick-up time.

3. For non-STAT order, on weekends, holidays, or after hours, urine specimens are delivered to and stored in the laboratory refrigerator located in the North 1 and South 2 Residence Buildings.. A designated A.M. shift nursing staff will bring all the urine specimens with requisitions to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.

4. Refer to Clinical Lab P&P for laboratory hours and courier pick-up hours.

1. For regular working hours, send urine specimens directly to the Clinical Laboratory by any Nursing Staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include urine specimen in the earliest lab courier pick-up time.

2. For non-STAT order, on weekends, holidays, or after hours, urine specimens are stored in the laboratory refrigerator located in the North 1 and South 2 Residence Buildings. A designated A.M. shift nursing staff will bring all the urine specimens with requisitions to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.

3. For STAT order, on weekends, holidays, or after hours, Licensed Nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation to pick-up specimen.

4. Refer to Clinical Lab P&P for laboratory hours and courier pick-up hours.

E. Documentation

1. Treatment Assessment Record (TAR)

   Licensed Nurse or unit clerk will transcribe physician's laboratory ordered test in the TAR. Licensed Nurse initials the TAR once specimen is obtained. Record the date, time, and method of collection in the reverse page of the TAR.

Laboratory Requisition Form -

See Procedure Section B.

2.

ATTACHMENTS:

Attachment 1 – Methods of Urine Collection using Midstream (Clean-Voided) Technique
Attachment 2 – Methods of Urine Collection using Intermittent Catheterization Technique
1. Treatment Assessment Record (TAR)

Licensed Nurse or unit clerk will transcribe physician's laboratory ordered test. Licensed Nurse to initial TAR once specimen is obtained. Record the date, time, and method of collection in the reverse page of the TAR.

REFERENCES:

Urine Specimen: Obtaining for Laboratory Testing – Indwelling Urinary Catheter. Walsh, K. and Mennella, H. authors. Cinahl information Systems; 2015 – electronic access on March 17, 2015.

Urine Specimen: Obtaining for Laboratory Testing – Intermittent Urinary Catheter. Walsh, K., author. Cinahl information Systems; 2015 – electronic access on March 17, 2015.

Urine Specimen: Obtaining Midstream (Clean-Voided). Caple, C., author. Cinahl information Systems; 2015 – electronic access on March 17, 2015

Elkin, Perry, Potter, Nursing Interventions & Clinical Skills, Mosby Inc., 4th edition, 2007.

Lippincott, Williams & Wilkins, Best Practices: Evidence Based Nursing, 2nd edition, Springhouse Corporation, 2007.

Nettina, S. The Lippincott Manual of Nursing Practice (9th Ed, 2010).

Kluwer, W., Lippincott, Williams & Wilkins. Lippincott's Nursing Procedures, 5th edition, 2009.

CROSS REFERENCES:

Nursing Policies and Procedures: H 6.0 STAT or Routine Clinical Laboratory Protocol
Nursing Policies and Procedures: F 5.0 Nursing Management of Indwelling Urinary Catheters

Departmental LH:A1 Clinical Laboratory Policies and Procedures
NPP F 5.0 Nursing Management of Urinary Catheter

Revised: 8/2001; 11/2008, 10/2010; 07/14/2015~~03/20/2015~~

Reviewed: ~~11/04/2010~~ 07/14/2015~~03/27/2015~~

Approved: 07/14/2015

1. ATTACHMENT 1 –Urine Collection Using Midstream (Clean-Catch) Technique

Description:

2. Midstream catch (clean-catch) technique is obtaining urine after the initial flow of urine.

3.1. Instructions for obtaining midstream catch:

a. Wash hands thoroughly and applydon on non-sterile gloves.

b. Sit the resident in the toilet seat.

c. Clean the periurethral area with antiseptic towelette prior to voiding.

Female: Spread the labia with the non-dominant hand. Using the towelette, clean the urinary opening by wiping one side of the labia from front of the labia towards the rectum (front to back). Repeat the same procedure on the other side of the labia using a new towelette. Then clean the urethral opening with a new towelette.

Male: Retract the foreskin (if present). Clean the urinary meatus and the glans with a towelette, moving outward in a circular motion. Then repeat procedure using a new towelette.

d. Instruct the resident to begin urinating. After a strong flow of urine, place the specimen container to collect the urine about 30 – 60 ml. Allow the resident to finish voiding.

e. Avoid touching the interior surface of the specimen container or lid to avoid contamination. Close the container lid tightly and wipe the outside of the container with a new toilette.

f. Wash hands thoroughly after the procedure.

4.2. Secure the specimen container and label with resident/patient identifiers -and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

REFERENCES:

Urine Specimen: Obtaining Midstream (Clean-Voided). Caple, C., author. Cinahl information Systems; 2015 – electronic access on March 17, 2015

New: 03/20/2015 07/14/2015

Reviewed: 07/14/2015

Approved: 07/14/2015

ATTACHMENT 2~~1~~ –Urine Collection Using Intermittent Catheterization

1. Gather necessary supplies. Provide privacy and explain the procedure and its purpose to the resident or family.

2. Perform hand hygiene and apply ~~don~~ on non-sterile gloves.

3. Provide good lighting.

4. Position resident with full ROM as follows:

   Female: Dorsal recumbent position (on back with knees flexed), have resident relax the thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip.

   Male: Supine position with legs extended and thighs slightly abducted.

   For residents with limited ROM, position for comfort with sufficient staff as needed.

5. If perineal area is visibly soiled, cleanse with l~~Wash the perineum with~~ approved hygiene ~~products~~ products~~warm soapy water and rinse thoroughly~~. Discard gloves and perform hand hygiene.

6. Established a sterile field nearby by the resident for easy access of the urinary catheter tray.

7. Apply ~~Don~~ on sterile gloves.

8. Remove the supplies from the catheter tray and organize them within the sterile field.

~~9. Check catheter for any defect.~~

~~10.~~9. Maintaining a aseptic non-touch technique, clean the external orifice as follows:

   Female:

   a. Using the non-dominant hand, exposes the meatus by spreading the labial folds to expose the urinary meatus.
   b. Once the urethra is visualized, maintain hand position to prevent recontamination.~~n external urinary orifice is exposed does not allow it to close, especially after the antiseptic cleansing agent has been applied.~~ If the labia closes after cleaning, the skin is considered contaminated and must be recleaned.
   c. Keep the non-dominant hand in this position for the remainder of the procedure—this hand is now unsterile. ~~Asks assistant to illuminate the meatus with a penlight, if needed.~~
   d. Using the dominant hand, clean with antiseptic swab one side of the vulva and perineal area using one swipe technique beginning from the one side of the clitoris, cleaning along the labia majora, labia minora, and adipose tissue and ending before the perianal area. Discard the antiseptic swab.
   e. Clean the other side of the vulva and perianal area using the same technique as stated above.
   f. With a new antiseptic swab, clean the center of the vulva using the one swipe technique beginning above the clitoris, wiping directly over the urethral meatus and ending before the perianal area.
   ~~g. Do not reuse antiseptic swabs over previously cleaned tissue.~~

Male:

a. Using the non-dominant hand, hold the penis and gently retracts the foreskin, if applicable. Once the urethra external urinary orifice is exposed, keeps the non-dominant hand in this position for the remainder of the procedure as this hand is non-sterile.
b. Using the dominant hand, apply antiseptic swab in a circular motion completely around the tip of the penis penisglans. Clean in a circular motion starting at the tip and working outward. Does not wash back and forth across the urethral opening.
c.b. Use separate sets of antiseptic swabs to complete three separate cleansing cycles cyclesircuits.
d. Do not reuse antiseptic swabs over previously cleaned tissue.

11.10. Generously lubricates the proximal tip of the catheter.

12.11. Using the dominant hand, grasps the catheter 3–4 inches from its insertion tip and secure coils the remainder of the catheter in the palm, if necessary, to keep the catheter sterile.

13.12. Insertion of intermittent catheter:

Female:

a. Asks the resident to cough or bear down as the catheter is inserted.
b.a. Slowly advances the catheter in a slightly downward direction (to track the slight curve of the urethra) through the urethra external urethral orifice toward the bladder, which is ~3–4 inches or until urine begins to flow.
b. Once urine appears, continues to advanceappears advance the catheter an additional 1–2 inches. to make certain that the catheter tip rests within the bladder.
Never force the catheter if meeting resistance.

c.

Male:

a. Hold the penis at a 70–90° angle to the patient's abdomen abdomenlegs. Gently stretches it upward to create a straight path through the penile portion of the urethra.
b. Ask the resident to bear down or cough as the catheter is inserted into the urethra.
c. Slowly advances the catheter through the urethra urethraexternal urethral orifice toward the bladder.
d.b. Continue to advance the catheter ~ 7–8 inches or until urine begins to flow.
c. Once urine appears, continuess to advance the catheter an additional 1–2 inches. to make certain that the catheter tip rests within the bladder.
Never force the catheter if meeting resistance.

e.d.

14. Never force the catheter.

15.13. Place the distal end of the urinary catheter within the sterile basin collection tray to obtain specimen specimenallow the urine to drain into the tray until the bladder is empty.

16. Prior to removing the catheter, rotate the catheter, if desired, to completely drain urine in dependent areas of the bladder.

14. Transfer the appropriate amount of urine to the sterile specimen container and attaches the lid securely and label specimen with resident/patient identifiers. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.
17.

18.15. With the dominant hand, slowly withdraw the catheter and discard discardallow it to fall into a garbage bag.

19. Clean the excess antiseptic and lubricant from the resident's genital area.

20. Assist the resident into a comfortable and safe position.

21. Discard all soiled materials and perform hand hygiene.

22. Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

REFERENCES[GEM1]**:**

Urine Specimen: Obtaining for Laboratory Testing – Intermittent Urinary Catheter. Walsh, K., author. Cinahl information Systems; 2015 – electronic access on March 17, 2015.

New: 07/14/2015~~03/20/2015~~

Reviewed: 07/14/2015~~03/27/15~~

Approved: 07/14/2015

AFTER HOURS OR STAT BLOOD DRAW OR ROUTINE CLINICAL LABORATORY PROTOCOL

POLICY:

1. A Registered Nurse (RN) may perform venipunctureis allowed to draw blood specimen for after hours and/or with STAT blood draw ordered by the physician.

2. The licensed nurse must notify the physician immediately if the specimen cannot be obtained.order to LHH resident either from venipuncture, or from Central Venous Access Device (CVAD), or Peripherally Inserted Central Catheter (PICC) lines following the SFGH Clinical Laboratories Manual for specimen collection and handling procedures.

Appropriate LHH staff are responsible for correct specimen collection and handling at times when a laboratory assistant is not available.

A physician's written order is required prior to any blood draw.

The licensed nurse must notify the physician immediately if the blood draw cannot be carried out.

PURPOSE:

To describe the procedureguideline to nurses when obtaining after hours STAT provide guidelines to RNs when obtaining blood drawspecimen.enable STAT and routine laboratory tests to be completed immediately or in a timely manner.

PROCEDURE:

1. For STAT blood draw orders, -when laboratory technician is unavailable or after hours, the licensed nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation arrangements to pick-up specimen.

2. For STAT-order, on regular working hours, inform Lab Technician to include lab specimen to the earliest lab courier pick-up time.

3. Refer to C 9.0 Transcription and Processing of Orders.

4. Licensed Nurse completes laboratory requisitions with stamped addressograph. Verify the physician's ID number, applicable pager number, ICD codes, pertinent medical diagnosis and medications. Indicate if STAT was orderedThe RN must check and verify the identification of the resident.

Label specimens with date and time[A1] collected, stamped addressograph.

5. The RN must check and verify the identification of the residentLicensed Nurse completes laboratory requisitions with stamped addressograph. Verify the physician's ID number, applicable pager number, ICD codes, pertinent medical diagnosis and medications. Indicate if STAT was ordered. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

6. Label specimens with date and time collected, stamped addressograph

7. Place each specimen in a separate specimen plastic bag with its own lab requisitionSecure the specimen container and place inside a specimen plastic bag.

8. Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

9. Licensed Nurse to initial TAR once specimen is obtained.

10. "Ward or Clinic Copy" to remain on requesting neighborhood.

11. STAT blood results are viewed on the electronic health records (EHR). Critical results are usually reported by phone to the unit licensed nurse or physician.

12. The Nurse documents the date, time, name of physician notified of the STAT tests results. The charge nurse or team leader is responsible for communicating the status of all STAT orders to the oncoming shift to ensure follow up.

The charge nurse or team leader is responsible for communicating the status of all STAT orders to the oncoming shift to ensure follow up.The Nurse documents the date, time, name of physician notified of the STAT tests results.

"Ward or Clinic Copy" to remain on requesting neighborhood.

Place each specimen in a separate specimen plastic bag with its own lab requisition.

Licensed Nurse to initial TAR once specimen is obtained.For STAT order, on weekends, holidays, or after hours, the RN will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation arrangements to pick-up specimen.

13.

The RN checks the physician's order and completes laboratory requisition slip (Refer to A1 Clinical Laboratory Procedures)

The licensed nurse of unit clerk may transcribe the physician's order in the Treatment Administration Record (TAR).

Prior to blood draw, the RN must check the identification of the resident by checking the resident's ID band.

APPENDIX:

Appendix 1: 1: Special Handling Instructions of Laboratory Specimen

~~A. The Physician writes the orders for Routine or STAT clinical laboratory tests. The Licensed nurse or Unit Clerk notes the orders and transcribes in the Treatment Assessment Record (TAR).~~

~~B. The phlebotomist is notified by the nurse/unit clerk and is responsible for obtaining the blood specimen from 0530 hours until 1615 hours on weekdays and from 1000 hours to 1400 hours on weekends and holidays. At all other times the nurse and physician are responsible when the phlebotomist is not available.~~

~~C. The Licensed Nurse, CNA, or PCA will assist the phlebotomist to identify and reassure residents on an as-needed basis. The Phlebotomist requires that resident is wearing an ID band or the nurse Identifying resident must sign the requisition. Positive Identification of resident name (not only room number) must be done by the phlebotomist before taking the specimen.~~

~~D. STAT orders~~

~~1. For STAT-order, on regular working hours, inform Lab Technician to include lab specimen to the earliest lab courier pick-up time.~~

~~2. For STAT order, on weekends, holidays, or after hours, Licensed Nurse to call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation arrangements to pick-up specimen.~~

~~3. The physician is to be notified immediately if the order cannot be carried out.~~

~~4. STAT blood results are viewed on the computer via the Resident Lifetime Clinical Record (LCR). Critical results are usually reported by phone to the unit RN or physician. Phone inquiries are obtained by calling 206-8590.~~

~~5. The charge nurse or team leader is responsible for communicating the status of all STAT orders to the oncoming shift to ensure follow up.~~

~~6. The Nurse documents the date, time, name of physician notified of the STAT tests results.~~

~~E. Routine clinical laboratory specimens~~

~~1. For regular working hours, send lab specimens directly to the Clinical Laboratory by any Nursing Staff for regular lab courier pick-up.~~

~~2. For non-STAT order, on weekends, holidays, or after hours, lab specimens are stored in the laboratory refrigerator located in the North 1 and South 2 Residence Buildings. A designated A.M. shift nursing staff will bring all the lab specimens with requisition to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.~~

~~3. Refer to Clinical Lab P&P for laboratory hours and courier pick-up hours.~~

~~F. To prepare the specimen for lab pickup:~~

1. Label specimens with date and time collected, stamped laboratory addressograph containing resident name, laboratory ID number, neighborhood, and bed number.

2. Tightly secure the specimen container and place inside a specimen plastic bag.

3. Licensed Nurse or lab tech completes laboratory requisitions with stamped laboratory addressograph (containing resident's name laboratory ID number, neighborhood, and bed number). Write the physician's ID number, applicable pager number, ICD -9 codes, pertinent medical diagnosis and medications. Indicate if STAT was ordered. Clipped or placed the laboratory requisitions in the outside pocket of the specimen plastic bag.

4. "Ward or Clinic Copy" to remain on requesting neighborhood.

5. See section D (STAT orders) and section E (Routine lab specimen).

G. Courier Services

Refer to Clinical Laboratory P&P for Courier Services

H. Clinical laboratory specimens [A2]for transport to SFGH need special handling to assure accuracy of results. Follow the special handling instructions indicated below:

SPECIMEN TYPE	TIME	SPECIAL HANDLING
Micro, chem., hematology, Blood bank	normal	LHH lab Refrigerator in brown paper bag during regular hours
All specimens after business Hours		pack in insulated bag with cold pack
Arterial Blood Gases Serum Ammonia PT, PTT etc.	Right Away	Sealed in plastic (biohazard) bag and placed in an insulated bag with cold pack.
Urine specimens Blood Chemistries Hematologies (CBC etc.) Sputum cultures	Within 30 minutes of when drawn	Refrigerator or insulated bag with cold pack
Blood cultures	NO more than ONE hour	NO refrigeration.
Other cultures in culture medium		Sealed in biohazard zip-lock plastic bag.

Transport in a brown paper bag.
Must be placed in incubator if there is delivery delay.

Note that laboratory staff must deliver 3 cooler bags and cold packs daily to the Clinical Laboratory in the Pavilion Mezzanine. If not, the courier must be contacted to bring these.

~~**I. When multiple tests are needed, place each specimen in a separate specimen plastic bag with its own lab requisition. For example, two urine specimen containers and requisitions are needed for urinalysis and culture/sensitivity. They go to different laboratories.**~~

~~**J. If there are problems encountered at any step in the protocol, the physician and nursing supervisor are to be notified immediately. The licensed nurse documents in Interdisciplinary Progress Notes date, time, and names of who was notified each time that notice is given.**~~

~~**K. Documentation:**~~
~~**Licensed Nurse to initial TAR once specimen is obtained. Record the date, time, and method of collection in the reverse page of the TAR.**~~

~~**L. If the Physician is doing a specimen collection that requires a Lumbar Puncture Tray or an Abdominal Paracentesis tray, these are available in Central Supply.**~~

CROSS REFERENCES:

A1 ~~Departmental LH:~~ Clinical Laboratory ~~Policies and~~ Procedures
A2 Phlebotomy Procedure
A3 Identification of Resident and Collection of Blood Specimen
A4 Blood Culture Procedure

NPP J 7.0 Central Venous Access Device (CVAD) Management
NPP J 7.1 Peripherally Inserted Central Catheters (PICC) Management
NPP J 8.0 Blood Transfusion

Revised: 3/2001; 1/2009; 10/2010; 07/14/2015~~03/13/2015~~

Reviewed: 07/14/2015

Approved: 07/14/2015
~~11/04/2010~~

Clinical laboratory specimens [A3]**for transport** to SFGH need special handling to assure accuracy of results. Follow the special handling instructions indicated below:

SPECIMEN TYPE	TIME	SPECIAL HANDLING
Micro, chem., hematology, Blood bank	normal	LHH lab Refrigerator in brown paper bag during regular hours
All specimens after business Hours		pack in insulated bag with cold pack
Arterial Blood Gases Serum Ammonia PT, PTT etc.	Right Away	Sealed in plastic (biohazard) bag and placed in an insulated bag with cold pack.
Urine specimens Blood Chemistries Hematologies (CBC etc.) Sputum cultures	Within 30 minutes of when drawn	Refrigerator or insulated bag with cold pack
Blood cultures Other cultures in culture medium	NO more than ONE hour	NO refrigeration. Sealed in biohazard zip-lock plastic bag.

Transport in a brown paper bag.
Must be placed in incubator if there is delivery delay.

Note that laboratory staff must deliver 3 cooler bags and cold packs daily to the Clinical Laboratory in the Pavilion Mezzanine. If not, the courier must be contacted to bring these.

OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS

POLICY~~IES~~:

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

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

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

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

PURPOSE:

Correct medications will be available and stored properly.

PROCEDURES:

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

B. Obtaining medication from Pharmacy

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

2. Maintenance Medications:

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

3. Short-term Medications:

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

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

5. Medication Refills

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

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

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

C. Labeling Medications

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

2. Label Changes:

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

D. Storage of Medications

1. Condition of Container and Contents~~:~~

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

2. Orderliness of Medications

   a. Medication Cart:

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

   b. Treatment cart:
      i. Ointments and creams are labeled with resident's name and are legible. All medication tubes and bottles are to have covers.
      ii. Irrigating solutions are checked for expiration date labeling. Normal saline and sterile water are ordered from Central Supply. Other irrigation solutions are ordered from Pharmacy and are labeled with expiration dates. Unlabeled or unopened expired solutions are to be returned.
      iii. When bottles of irrigation solution are first opened, write the date, time and nurse's initials on the label. Refer to Pharmacy Policy 02.01.06 Appendix 1 for expiration policies and practice.

iv. Irrigation solutions are not to be used after expiration dates determined by Pharmacy and the time the container is first opened.

c. Medication Room

Licensed nurse checks expiration dates of medications before administering medication and on weekly or monthly basis.

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

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

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

a. Refrigerator temperature is ~~checked twice daily by licensed nurse. The temperature is to be between 2 degrees centigrade (36 degrees Fahrenheit) and 8 degrees centigrade (46 degrees Fahrenheit).~~monitored continuously via wireless refrigerator monitoring system. The temperature log is checked twice daily by nursing staff (~~. (~~Refer to ~~see~~ LHH~~HW~~PP 31-01)~~)~~.
b. Store oral medications together in one area, refrigerated injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.
c. No food or specimens are to be placed in the biological refrigerator.

4. Emergency Drug Box / Crash Cart

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

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

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

E. Handling Medications

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

2. Holding Medications

Hold Meds = Discontinuation (D/C) (Refer to LHH~~HW~~PP 25-05).

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

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

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

5. Multidose Vials:

   a. Multiple dose vials of injectables shall be visually inspected prior to use and discarded if any of the following occur:
      i. There is a change in appearance of the solution.
      ii. There is damage or loss of integrity of the closure.
      iii. The drug has been improperly stored.
      iv. The vial is known or suspected to be contaminated

   b. Expiration Dating (Refer to Pharmacy Policy 02.01.06 Appendix 1).

   c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.

   d. Insulin vials shall be:
      i. Dated upon initial entry.
      ii. Open vials may be kept in individual resident cassettes or in the refrigerator.
      iii. Open, in-use vials shall be discarded after 28 days.
      iv. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

   e. Injectables that contain preservatives shall be:
      i. Dated upon initial entry.
      ii. Refrigerated for stability, if recommended by the manufacturer.
      iii. Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).

6. Resident Transfers:

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

7. Discontinued Medications:

   a. Immediately after the medication is discontinued, send or fax the order to Pharmacy, print "DC" on the prescription label and place the medication in the pharmacy pick-up box. This also applies to the medications of residents who expire.

   b. Resident Discharges:

      i. When a resident is discharged to any acute setting all medications must be returned to pharmacy.

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

F. Monthly Pharmacy Ward Survey

1. The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered to the resident to ascertain that medications are given accurately and with acceptable infection control measures employed.

2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.

G. Out-On-Pass Medications

1. For planned trips away from the hospital, the attending physician is to write an order for each out-on-pass medication, including the number of days needed. The order shall include the name of the medication, strength, and directions for use.

   a. The nurse will have the order filled at the hospital Pharmacy.
   b. The pharmacist will dispense the medications in properly labeled child-proof containers.
   c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.
   d. A security prescription form is necessary for all ~~Outpatient~~ out on pass controlled substance prescriptions. Alternatively, except CII controlled substance prescriptions, physician may fax prescriptions for CIII-V to the pharmacy on a regular physician order form.

2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.

   a. Controlled substances **may not** be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.
   b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.
   c. The physician will counsel the resident on proper use of his/her medications.

3. The nurse will note in the Medication Administration Record that the resident is out on pass with a supply of medication.

H. Personal Medication

1. Medications brought into LHH with the resident at admission:

   a. Will be given to family or guardian to take home.
   b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.
   c. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician writes the order to use them.

d. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to give the medication unless it has been relabeled by LHH Pharmacy.

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

3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

CROSS REFERENCES:

LHHPP File: 25-01 High Risk - High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 31-01 Wireless Refrigerator and Freezer Temperature monitoring System

LHH Pharmacy Administration P&P 01.01.01 Accessibility to Medications
LHH Pharmacy Administration P&P 01.02.02 Stop Orders
LHH Pharmacy Administration P&P 01.08.00 Extern Students
LHH Pharmacy Administration P&P 02.02.00 Controlled Substance
LHH Pharmacy Administration P&P 02.01.06
Pharmacy Administration P&P 09.01.00 Automated Medication Dispensing Cabinets

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

Adopted from NPP J 1.0 12/2006

New: 4/2010

Revised: 03/17/2011; 07/14/2015

Reviewed: 07/14/2015~~03/24/2011~~

Approved: 07/14/2015~~03/24/2011~~

MANAGEMENT OF RESIDENT~~S~~ ON HEMODIALYSIS

POLICY:

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

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

3. Nursing interventions for pre and post hemodialysis care are planned along and the dialysis center phone numbers for routine and emergency consultation.

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

5. Dialysis catheters are NEVER used for blood draws or IV hydration.

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

~~5. Dialysis catheters are NEVER used for blood draws or IV hydration.~~

~~6. The licensed nurse will monitor the AV shunt and fistula for audible bruit and palpable thrill every shiftat least daily and report absence of bruit and/or thrill to the LHH physician..~~

PURPOSE:

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

PROCEDURE:

A. Care Before Dialysis

1. LHH staff prepare resident for transport to dialysis treatment.

   a. Notify physician and dialysis nurse prior to transporting if resident has symptoms of acute illness.
   b. The team may decide that transporting to the clinic is still necessary, but precaution such as a patient mask, may be indicated. For cases of contagious illness – such as the flu, notification/consultation with the infection control nurse is also appropriate to contain the spread of infection.
   ~~b.~~c. Vital signs and weigh are taken on the neighborhood prior to sending resident to dialysis. Weigh resident at the same time each day, on the same scale with the same amount of clothing.

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

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

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

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

B. Care Immediately After Dialysis

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

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

~~2.~~ 3. Receives a resident status report from the dialysis nurse to include:

a. dry weight from dialysis
~~a.~~b. fluid status/balance
~~b.~~c. vital signs/tolerance of procedure
~~c.~~d. lab tests and results
~~d.~~e. medications given or with held
~~e.~~f. blood transfusion if given
~~f.~~g. unusual events
~~g.~~h. type of temporary hemodialysis access

4~~3~~. Assesses for any bleeding at the access site upon return from dialysis.

5~~4~~. Assesses shunt for thrill and bruit. If pulsation is absent, notifies the physician immediately.

6~~5~~. Perform vital signs upon return from dialysis and prn unless ordered otherwise. Report any significant changes to the physician.

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

C. Vascular Access Precautions

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

2. Blood pressure measurements cannot be taken on the extremity which has dialysis access.

3. Venipuncture for laboratory tests, I.V. fluids, or taking blood pressure may not be performed on the extremity with dialysis access.

- A sign should be posted at the head of the bed to **alert** health team members not to use extremity with shunt or fistula.

D. Tunneled Dialysis Catheter Care

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

2. Neighborhood RN may perform dressing reinforcement if dressing is soiled or loosened.
~~2. Strict sterile technique must be practiced.~~

~~**E. Care Between Dialysis Treatments**~~

~~Vital signs and weight are taken on the neighborhood prior to sending resident to dialysis.~~
~~1. are taken daily and prn for assessment of the resident's physical condition.~~

~~Vital signs are taken upon resident return from dialysis.~~

~~Weigh resident at the same time of day, on the same scale with the same amount of clothing[GEM1].~~

~~Fluid Monitoring (refer to NPP G 3.0 Intake & Output).~~
~~2. If resident's weight remains stable, weigh weekly and record.~~

~~If weights are not stable or if resident has shortness of breath or increasing edema, weigh and record daily. Weigh resident at the same time of each day, on the same scale with the same amount of clothing[GEM2].~~

~~3. Fluid Monitoring (refer to NPP G 3.0 Intake & Output)~~

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

~~4. Oral hygiene (refer to Oral Hygiene P&PNPP D3 1.0 Oral Hygiene)~~

~~a. Teach resident to use a soft toothbrush to gently brush teeth and gums. Use appropriate mouthwash as needed to reduceing a pleasant tasting mouthwash or dilute vinegar mouthwash may improve the uremic taste in the mouth.~~
~~b. Sour candies or lemons may improve the taste in the mouth and decrease thirst.~~

~~5. Skin care~~

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

~~**F.**~~ **Resident Education**~~**teaching**~~

~~1.~~**E.**~~Emphasize resident's crucial role in protecting vascular access.~~

~~2.~~1. Explain precautions for the extremity with the vascular access.

~~3.~~2. ~~Teach~~ Educate resident to ~~assess venous patency, if is able to do so.~~ report any changes or problems to vascular access.

~~4.~~3. ~~Teach~~ Educate importance of following fluid intake limitations and appropriate diet.

~~G.~~F. Documentation

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

2. Treatment Assessment Record (TAR)
   a. ~~Assess~~ ~~Monitor~~ Document presence or absence of AV shunt/fistula ~~for~~ audible bruit and palpable thrill ~~.~~
   b. Condition ~~±site~~ of dialysis access site.

3. LCR~~Weight Graphic Sheet~~: H~~h~~eight and W~~w~~eight ~~on each page~~

4. Interdisciplinary Progress Notes

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

~~5.~~8. Neighborhood Census Report: Outpatient hemodialysis is considered a clinic visit and therefore, is to be documented on the unit census report.

~~6.~~9. ~~Resident Dialysis Binder~~ ~~[GEM3]~~ ~~:~~Dialysis Communication Form: Communication via secured fax ~~To coordinate~~ between dialysis nurse and unit nurse ~~, place~~ resident's ~~changes or~~ information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)

APPENDICES:

~~1.~~ Appendix 1: Hemodialysis Communication Guidelines
~~2.~~ Appendix 2: ~~Hemodialysis Communication Form~~ ~~[GEM4]~~ Dialysis Communication Form
Appendix 3: Resident Care Plan Hemodialysis
~~3.~~ Appendix 4: Dialysis TAR T~~t~~emplate

REFERENCES:

Lippincott Manual of Nursing Practice, 9th Edition, Wolters Kluwer. Lippincott ~~Best Practices: Evidence Base Nursing Procedures, 2nd Edition Springhouse Corporation, Lippincott,~~ Williams & Wilkins, 201~~007~~

CROSS REFERENCES:

NPP D3 1.0 Oral Hygiene
~~Nursing Policies and Procedures~~NPP~~:~~ J 7.0 Central Venous Access Device (CVAD) Management
~~Nursing Policies and Procedures:~~NPP G 3.0 Intake and Output

Adopted: 08/2000

Revised: 03/2006, 4/2008, 10/2010; 07/14/2015

Reviewed: 07/14/2015

Approved: 07/14/2015~~10/31/2010~~

Coordination of Care for LHH ~~Patients~~ Residents Requiring Outpatient Hemodialysis

~~**Policy:**~~

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

Background:

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

Guidelines:

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

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

Origination: 8/2006

Revised: 2/2008; 07/14/2015

Reviewed: 07/14/2015

Approved: 07/14/2015~~dbv~~

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd.
San Francisco, CA 94116

Dialysis Center _____
Phone _____

Unit _____ Phone _____

INSTRUCTIONS: LHH Nursing and Dialysis Staff, please use this form to communicate any information relevant to the resident. FAX securely between sites.

FROM LAGUNA HONDA HOSPITAL TO DIALYSIS CENTER

REPORT BY _____ UNIT PHONE: (415) 682- __ __ __ __ DATE: _____

REPORT

_____
_____
_____
_____
_____

FROM DIALYSIS CENTER TO LAGUNA HONDA HOSPITAL

__ Attached (via FAX) copy of most recent lab results post-dialysis
__ Dry weight from dialysis today _____
__ Patient had meal YES __ % eaten ___ NO ___ N/A ___
__ Patient fluid intake YES __ amount ____ NO ___ N/A ___
__ Supplemental Nutrition vial parenteral route: YES __ amount ____ NO ___ N/A ___

Medications given during dialysis: FAX attachment or document below and FAX back

MEDICATION DOSE ROUTE TIME
_____
_____
_____

VITAL SIGNS: _____
__ Tolerated procedure YES ___ NO ___
__ Blood Transfusion YES ___ NO ___
__ Unusual Events YES ___ NO ___
__ Temporary Hemodialysis Access YES ___ NO ___ INDICATE _____
__ Other comments

RN COMPLETING REPORT _____ DATE _____

PHONE _____

RESIDENT CARE PLAN
375 Laguna Honda Boulevard
San Francisco, CA 94116

Laguna Honda Hospital

Write legibly in black ink

Addressograph

Start Date Initial	Problem/Need	Goal	Target Date	Date – Intervention	Resp Svc	D/C Date Initials
	Chronic renal failure – on	Resident will go to		Report any changes in resident's physical or		
	hemodialysis	hemodialysis on a regular		emotional status or new MD orders to dialysis		
		schedule to maintain		nurse or technician		
		appropriate electrolyte				
	Type of dialysis access,	balance		Use Dialysis Communication Form to communi-		
	catheter & location:			cate any information relevant to the resident and		
		Dialysis shunt/catheter will		fax the form securely between sites.		
		remain patent w/o S/Sx of				
	CONTACT INFORMATION	infection.		Post dialysis, review the Dialysis Communication		
				Form for report from the dialysis such as		
	Resident's Nephrologist			any abnormal labs, V/S, and weight; or		
	and Pager #:			medication given during dialysis; or if given		
				blood transfusion; or unusual events during		
				or while in the dialysis site; or change in dialysis		
	Dialysis Center Name:			venous access device. Notify physician of		
				pertinent information or changes.		
	Dialysis Center Phone #:			Assess for any bleeding at access site upon		
				return from dialysis. If uncontrolled bleeding,		
				apply direct pressure to the access site &		
	Dialysis Schedule:			notify MD.		
				Assess shunt for bruit and thrill Q shift		
	Have resident ready for			(while awake)		
	pick-up by: _____					
	Phone #:			**DO NOT** use access device to take B/P, start		
				IV, or draw blood.		
				No constrictive clothing or jewelry on dialysis		
				extremity.		
				Follow diet order as prescribed.		
				Record fluid or oral intake if on fluid restriction.		

RESIDENT CARE PLAN **Laguna Honda Hospital**
375 Laguna Honda Boulevard
San Francisco, CA 94116

Write legibly in black ink **Addressograph**

Start Date Initial	Problem/Need	Goal	Target Date	Date – Intervention	Resp Svc	D/C Date Initials
Con't.	Chronic renal failure – on			Weigh weekly and record if resident's weight		
	hemodialysis			remains stable.		
				Provide resident with education and support re		
				plan of care.		
				V/S daily and upon return from dialysis.		

Medication/Treatment Record

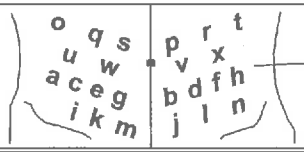
MONTH / YEAR:

ALLERGIES:

☐ No Known Allergies

INJECTION SITE CODE

1. Gluteus left
2. Gluteus right
3. Deltoid left
4. Deltoid right
5. Thigh left
6. Thigh right



May be used if necessary (o-x)

Iliac Crest

Preferred site (a-n)

☐ Medication ☐ Treatment

	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Check AV shunt or fistula for audible bruit and palpable thrill every shift	AM																															
	DAY																															
	PM																															
Check V/S and weight prior to dialysis treatment																																
Check V/S upon return from dialysis treatment																																
No blood draw or BP on _____ (site)																																
	F																															
	Y																															
	I																															

Initials	RN/LVN Signature	Initials	RN/LVN Signature	Initials	RN/LVN Signature	Initials	RN/LVN Signature	Initials	RN/LVN Signature

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd.
San Francisco, CA 94116

LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY DEPARTMENT SAFETY & EMERGENCY PREPAREDNESS PLAN

Background:

The Safety & Emergency Preparedness Committee of Laguna Honda Hospital provides safety & disaster readiness leadership. The Committee plans, executes & evaluates Hospital-wide disaster preparedness drills so that staff will be trained & ready to respond in a major emergency. The Committee is also charged with examining safety issues & implementing programs to ensure the safety of all Hospital residents, staff & visitors.

Policy:

The pharmacy staff will be trained on current safety issues and emergency preparedness programs established by the Laguna Honda Hospital's Safety & Emergency Preparedness Committee. Knowledge of these issues and programs will aid the department to address ongoing safety & emergency preparedness items. Regular & routine monitoring & discussion of safety related issues will keep on-the-job accidents to a minimum & also prepare the staff to respond appropriately in an established Hospital emergency preparedness drill or in an actual incident such as an earthquake or fire.

Procedure:

1. The pharmacy staff will receive regular (annual) training on safety issues, accident/illness prevention programs, and disaster plans through hospitalwide inservices and during regular departmental staff meetings. Special staff meetings shall be scheduled as needed to address urgent safety issues.

2. A pharmacy staff member will conduct ~~quarterly~~ monthly safety inspections in pharmacy work areas & will complete the Departmental Safety Inspection form (attachment 1).

3. The Departmental Safety Inspection form shall be kept on file in the Director's Office.

4. In a disaster or disaster drill, the disaster call back plan shall be initiated (04.01.01 attachment 1).

5. If an individual on the pharmacy staff has a safety issue or emergency preparedness concern, he or she shall contact the Pharmacist In Charge or the Pharmacy Director. The PIC or Pharmacy Director will determine the urgency of the issue & will take appropriate action for follow-up & review.

New: 3/94 RF
Reviewed: 02/05dw, 02/06, 01/08, 04/09
Revised: 10/09, 2/10, 6/11, 6/15

LH PHARMACY SAFETY CHECKLIST

Date_____

PHARMACY:

Doors to Pharmacy are locked and secure. Y N

Fire extinguisher is visible. Y N

Fire extinguisher have been inspected monthly by F.S.O. Y N

Razor blades and scissors are in labeled containers. Y N

Work areas (including floor) are clean and free of clutter. Y N

Electrical appliances are plugged in appropriate outlets (not overloaded). Y N

Storage of glycerin and acetic acid are in separate areas. Y N

MSDS are updated and are readily retrievable in the pharmacy. Y N

Disposable sharps container is in place Y N

Flammable items are stored properly and sign is posted. Y N

IV ROOM:

Work area (including floor) is clean and free of clutter. Y N

Cytotoxic waste container is less than 3/4 full. Y N

MSDS for hazardous materials is posted. Y N

Spill kit is available. Y N

Spill kit procedure is available. Y N

Eyewash station is present. Y N

NOTABLE OBSERVATIONS:_____

_____

FOLLOW UP DONE: _____

INSPECTED BY: _____

PHARMACY DIRECTOR'S SIGNATURE: _____

LAGUNA HONDA PHARMACY SAFETY CHECKLIST
MONTH_____YEAR_____

FIRE EXTINGUISHERS ARE VISIBLE.	Y	N
FIRE EXTINGUISHERS HAVE BEEN INSPECTED MONTHLY	Y	N
DISPOSABLE SHARPS CONTAINERS IN PLACE (LESS THAN ¾ FULL)	Y	N
BLACK WASTE CONTAINER IN PLACE (NICOTINE PATCH, COUMADIN)	Y	N
CHEMO/HAZARDOUS WASTE CONTAINER IN PLACE (LESS THAN ¾ FULL, LESS THAN 90 DAYS SINCE 1ST USE)	Y	N
WORK AREAS ARE CLEAN AND FREE OF CLUTTER	Y	N
EYE WASH STATIONS HAVE BEEN INSPECTED MONTHLY	Y	N
REFRIGERATOR TEMP PAGER BATTERIES GOOD	Y	N
CHEMO SPILL KIT AVAILABE IN SDR AND OVERSTOCK IV ROOM SUPPLY SHELF NEAR FIRE EXTINGUISHER	Y	N
CHEMO SPILL KIT PROCEDURE IS POSTED.	Y	N
CACTUS SINK FOR DRUG WASTE BATTERY OK	Y	N

NOTABLE OBSERVATIONS:_____
_____
_____

FOLLOW UP DONE:_____
INSPECTED BY:_____
PHARMACY DIRECTOR SIGNATURE:_____

LAGUNA[SJR1] **HONDA HOSPITAL**
04.01.01
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR DUTIES AND RESPONSIBILITES DURING DISASTERS AND DISASTER DRILLS

Policy:

The Pharmacy Department shall participate in Hospital-wide disaster drills. In an actual disaster Pharmacy Staff shall be available and prepared to assist the disaster team as required.

Purpose:

To assure the availability of appropriately trained and educated staff for the provision of pharmaceutical care during a disaster or disaster drill.

Procedure:

I. In an actual disaster, the call back of Pharmacy Staff as outlined in the Hospital wide disaster plan for the Department shall be initiated (attachments 1 & 2).

~~II. Two disaster drug kits (attachment 3) shall be prepared by Pharmacy Staff and kept in the Pharmacy for use during disasters and disaster drills.~~

~~A. The contents of the disaster drug kits shall be inspected monthly for expired or soon to expire drugs.~~

~~B. Replacement drugs shall have an expiration date of at least one year.~~

~~C. The disaster drug kit inventory log (attachment 4) shall be dated and signed after each inspection and the drug expiration date information shall be updated if necessary.~~ [SJR2]

~~III. When notified of a disaster or disaster drill, pharmacy personnel shall be prepared to take disaster drug kits to any designated treatment areas.~~

~~A.~~D. ~~If a disaster drug kit is requested during a disaster ***drill***, the disaster drug kit shall be retained in the possession of the pharmacy staff member at all times.~~

~~B.~~E. ~~In an actual disaster, the disaster team nurse of physician may sign a receipt (attachment 5) for the drug kit, and the kit may be left in the treatment area.~~

~~C.~~F. ~~All controlled substances used in an actual disaster shall be documented on the controlled substance Inventory Sheet (attachment 6).~~

~~D.~~G. ~~All signed and completed disaster kit receipts and Controlled Substance inventory sheets shall be forwarded immediately to the Pharmacy for filing.~~ [SJR3]

~~IV.~~II. Pharmacy Staff shall coordinate procurement and delivery of any medication needed but not available at the treatment site(s).

~~V.~~III. Pharmacists shall provide drug information consultation to treatment physicians and nurses as requested.

~~VI.~~IV. Upon request, Pharmacists shall assist physicians and nurses during an actual disaster by administering medications to residents and disaster patients.

~~VII.~~V. Pharmacy Department staff shall receive annual inservice education and training on disaster procedures and responsibilities.

NEW: 12/94 SK
REVISED: 4/98 SK, 2/05 dw, 04/08, 10/09, 6/15
RETYPED: 10/03 BT
REVIEWED: 02/06, 04/09, 2/10, 4/11