List of Hospital-wide/Department Policies & Procedures
Submitted to JCC for Approval on November 9, 2015

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

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Policy &amp; Procedure Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHPP 21-03</td>
<td>Admission Record</td>
<td>Health Information Systems departmental policy converted to hospital wide policy due to the impact on multiple departments.</td>
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<tr>
<td>LHHPP 21-08</td>
<td>Concurrent Quantitative Analysis</td>
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<td>Transcribed Reports</td>
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<tr>
<td>LHHPP 21-12</td>
<td>Record Requests</td>
<td>Health Information Systems departmental policy converted to hospital wide policy due to the impact on multiple departments.</td>
</tr>
<tr>
<td>LHHPP 21-13</td>
<td>Authorization for Use and Disclosure of Protected Health Information</td>
<td>Health Information Systems departmental policy converted to hospital wide policy due to the impact on multiple departments.</td>
</tr>
<tr>
<td>LHHPP 21-14</td>
<td>Access To Health Records By Ombudsman</td>
<td>Health Information Systems departmental policy converted to hospital wide policy due to the impact on multiple departments.</td>
</tr>
<tr>
<td>LHHPP 21-15</td>
<td>Access to Health Records</td>
<td>Health Information Systems departmental policy converted to hospital wide policy due to the impact on multiple departments.</td>
</tr>
<tr>
<td>LHHPP 45-02</td>
<td>Employee Development Fund</td>
<td>To assure that the acceptance and expenditure of donations earmarked for staff development meet the requirements of the source of funding and City procedures for expenditure.</td>
</tr>
</tbody>
</table>

2. **b. New Department Policies and Procedures**

**Department: Central Supply Services**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-01</td>
<td>Annual Physical Inventory Count</td>
<td>Created to provide an annual accounting of on-hand quantities in inventory, as well as a financial value of inventory.</td>
</tr>
<tr>
<td>F-02</td>
<td>Cycle Counts</td>
<td>Created to ensure cycle counts are regularly scheduled, tracked and discrepancies reported and researched.</td>
</tr>
<tr>
<td>Policy Number</td>
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</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F-03</td>
<td>Inventory Discrepancy Reporting</td>
<td>Created to provide management oversight on manual inventory adjustments.</td>
</tr>
<tr>
<td>F-04</td>
<td>Obsolete and Expired Products</td>
<td>Created to provide a guideline for obsolete and expired products.</td>
</tr>
<tr>
<td>F-05</td>
<td>CSR Inventory Security</td>
<td>Created to reduce the risk of unauthorized loss of supplies.</td>
</tr>
<tr>
<td>F-06</td>
<td>Record Retention for Files</td>
<td>Created to provide guidelines for storage and retention of purchasing, inventory, management, and receiving records for staff.</td>
</tr>
</tbody>
</table>

**Department: Nutrition Services**

<table>
<thead>
<tr>
<th>Policy Number</th>
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<th>Comments/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.80</td>
<td>Proper Mopping of the Floor</td>
<td>Standardized procedure per manufacturer’s instructions on chemical used for mopping the floor.</td>
</tr>
<tr>
<td>1.85</td>
<td>Galley Sanitation – Using the Galley to Sanitize the Resident Meal Trays</td>
<td>Creation of policy for galley sanitation procedure.</td>
</tr>
</tbody>
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2. **a. Revised Hospital-wide Policies and Procedures**

<table>
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<tr>
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<tbody>
<tr>
<td>LHHPP 01-03</td>
<td>Hospital Organization Chart</td>
<td>Organizational chart will be posted on the intranet accessible by all staff instead of distributed hospital-wide.</td>
</tr>
<tr>
<td>LHHPP 01-05</td>
<td>Distribution and Production of Collateral Materials</td>
<td>Description of collateral material provided and alignment with San Francisco Health Network style guide.</td>
</tr>
<tr>
<td>LHHPP 01-06</td>
<td>Administrator On Duty</td>
<td>Clarification of administrator on duty to have oversight during non-business hours.</td>
</tr>
<tr>
<td>LHHPP 01-07</td>
<td>Posting Notices, Hanging Artwork, And Caring For The Buildings</td>
<td>Minor verbiage adjustments, as well as the addition of reporting visible occurrences of damage to Environmental or Facility Services.</td>
</tr>
<tr>
<td>LHHPP 01-08</td>
<td>Media Relations Policy</td>
<td>Officer contact information was updated to reflect change in staff.</td>
</tr>
<tr>
<td>LHHPP 22-03</td>
<td>Resident Rights</td>
<td>Department of Public Health Licensing and Certification address and contact information updated.</td>
</tr>
<tr>
<td>LHHPP 28-02</td>
<td>The Farm and Therapeutic Gardens</td>
<td>Clarification that fruits and vegetables from the gardens are not for consumption by residents and are to be grown inside the greenhouse.</td>
</tr>
<tr>
<td>LHHPP 28-04</td>
<td>Pool Servicing And Aquatic Area General Maintenance</td>
<td>Clarification that each pool shall be covered when complex is closed for maintenance.</td>
</tr>
<tr>
<td>LHHPP 31-03</td>
<td>Clinical Product and Device Evaluation</td>
<td>Revision of subcommittee to committee.</td>
</tr>
<tr>
<td>LHHPP 35-03</td>
<td>Hospital Parcel Service</td>
<td>Clarification that resident parcels and packages will be sorted and delivered to the respective nursing stations for distribution.</td>
</tr>
<tr>
<td>LHHPP 72-01 A5</td>
<td>Surveillance Plan for Control of Nosocomial Infections</td>
<td>Revision of “Infection Control Nurse” to “Infection Prevention and Control Officer” and updates to current surveillance procedures.</td>
</tr>
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<tr>
<td>--------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LHHPP 72-01 C1</td>
<td>Alphabetical List of Diseases/Conditions with Required Precautions</td>
<td>Update of Alphabetical List of Diseases/Conditions with Required Precautions.</td>
</tr>
<tr>
<td>LHHPP 76-02</td>
<td>Smoke and Tobacco Free Environment</td>
<td>Incorporation of search of person, belongings and resident room for those who have violated the smoking policy, as well as meeting with RCT members to discuss plan of care to prevent further violations. Deletion of Laguna Honda Smoke Free Campus Message Line.</td>
</tr>
<tr>
<td>LHHPP 84-01</td>
<td>Student Affiliations</td>
<td>Inclusion of signature card components.</td>
</tr>
<tr>
<td>LHHPP 90-04</td>
<td>Parking on Laguna Honda Hospital Campus</td>
<td>Inclusion of review of special events as related to parking on the LHH campus.</td>
</tr>
</tbody>
</table>

### b. Revised Department Policies and Procedures

**Department: Facility Services**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Facility Services US-5</td>
<td>Domestic Hot Water Monitoring</td>
<td>Inclusion of random testing of hot water temperature of patient sink in each building during each shift.</td>
</tr>
</tbody>
</table>

**Department: Nursing Services**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
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</thead>
<tbody>
<tr>
<td>D9 8.0</td>
<td>Charging of Electric Wheelchair</td>
<td>Re-title from Electric Wheelchair Battery Charging. Change in policy statements including approved areas where to charge electric wheelchairs (inside resident’s room and living rooms only), charging of electric wheelchair no longer than 8 hours, responsibilities of P.M and A.M shifts. Deleted “Background” information. Simplify charging of electric wheelchair procedure. Updated cross-references.</td>
</tr>
<tr>
<td>NPP G 1.0</td>
<td>Vital Signs</td>
<td>Minor edits on policy statement. Pervious policy statement #3 was moved to procedure section. Major change in procedure section B describing how to monitor and document target behaviors in the BMR and side effects of medications used. Updated cross-references.</td>
</tr>
<tr>
<td>NPP M 16.0</td>
<td>Protocol For Resident Escort Off Hospital Grounds</td>
<td>Protocol added as an appendix to the P&amp;P.</td>
</tr>
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</table>

**Department: Nutrition Services**

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<tr>
<th>Policy Number</th>
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<tbody>
<tr>
<td>1.27</td>
<td>Sign in Sheets</td>
<td>Changed procedure for the Department from daily to weekly.</td>
</tr>
<tr>
<td>1.28</td>
<td>Employee Work Rules</td>
<td>Added new locker locations.</td>
</tr>
<tr>
<td>1.3</td>
<td>Disaster Planning</td>
<td>Changed emergency menu par to 2,000 count.</td>
</tr>
<tr>
<td>1.6</td>
<td>Menu Development Process</td>
<td>Revised the process to include a team collaboration from the menu committee, which includes recipe developed by the chefs</td>
</tr>
</tbody>
</table>
and cooks as well as adding the CBORD system into the process after the final approval from the Chief Dietitian.

1.7 Weekly Menus
Updated to include menus in Tagalog; changed the wording of “Nursing Wards” to “Neighborhoods”.

1.71 Replenish Juice and Coffee Dispensers in the Neighborhoods
Updated with the change in juice dispenser for apple and orange juice; added the procedure to delivery bulk cranberry juice inside the galley refrigerator.

1.77 Fire and Fire Drills
Updated with the change in the evacuation routes out of the Kitchen.

1.9 Menus Special Events
Updated to current practice of special events throughout the year.

1.106 Blast Chiller Operational Procedure
Revised to include the current practice of cooks checking food temperatures and getting a printed recording of the cool down for tracking and monitoring. Renumbered from 1.104 to 1.106.

1.117 Cafeteria Cash Sales Record and Handling
Updated to be in-sync with the policy in the Finance Department including how to handle credit card transactions. Renumbered from 1.115 to 1.117.

1.139 Unusual Occurrence Report
Updated to current practice of filing on line. Renumbered from 1.137 to 1.139.

1.153 Paycheck Distribution
Updated to current practice of direct deposit and electronic access to paycheck information. Renumbered from 1.151 to 1.153.

1.167 Making Deliveries to North Mezzanine
Updated with the change in Nursing locking the doors and storing carts after a meal service. Renumbered from 1.165 to 1.167.

3. a. Hospital-wide Policies and Procedures For Deletion

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<tr>
<th>Policy Number</th>
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<tbody>
<tr>
<td>None</td>
<td>N/A</td>
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b. Department Policies and Procedures for Deletion

**Department: Health Information Systems**

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<tr>
<td>HIS 1.02</td>
<td>Protect Health Information Documentation</td>
<td>Policy is represented in LHHPP 21-05 Medical Record Documentation.</td>
</tr>
<tr>
<td>HIS 3.02</td>
<td>Fax Transmission</td>
<td>Policy is represented in LHHPP 21-02 Transmission of Confidential Medical Information via Fax.</td>
</tr>
<tr>
<td>HIS 4.02</td>
<td>Admission Record</td>
<td>Converted to LHHPP 21-03.</td>
</tr>
<tr>
<td>HIS 6.01</td>
<td>Concurrent Quantitative Analysis</td>
<td>Converted to LHHPP 21-08.</td>
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<td>Converted to LHHPP 21-09.</td>
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<td>HIS 9.01</td>
<td>Physician Order Processing</td>
<td>Converted to LHHPP 21-10.</td>
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<td>HIS 10.01</td>
<td>Transcribed Reports</td>
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<td>Record Requests</td>
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<td>Converted to LHHPP 21-14.</td>
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<td>HIS 13.05</td>
<td>Resident Access to Health Records</td>
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<tr>
<td>NPP B 12.0</td>
<td>Review of Developmentally Disabled Resident Rights</td>
<td>Duplicate procedures covered in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.</td>
</tr>
<tr>
<td>NPP M 13.0</td>
<td>Wound V.A.C. Protocol</td>
<td>Duplicate P&amp;P. Converted to hospital-wide P&amp;P as LHHPP File #24-23 Negative Pressure Wound Therapy (NPWT) System on November 25, 2014.</td>
</tr>
</tbody>
</table>
ADMISSION RECORD

POLICY:

The health record shall be developed on admission and maintained for each patient/resident admitted to Laguna Honda Hospital.

PURPOSE:

To facilitate patient care and quality assessment.

PROCEDURE:

1. Attending Physician
   a. Completes all required medical information as outlined in medical staff bylaws.

2. Health Information Services
   a. Processes, assembles, analyzes, codes and stores all patient/resident health records according to the department’s policies and procedures and compiles needed statistics.

3. All Other Services
   a. Refer to the respective department’s Policy and Procedure section.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
CONCURRENT QUANTITATIVE ANALYSIS

POLICY:

Concurrent quantitative analysis of each patient's/resident's medical record is conducted by the Health Information Services department unit analyst.

PURPOSE:

To facilitate the availability of completed protected health information that may be used for patient/resident care and reimbursement purposes.

PROCEDURE:

Concurrent analysis is performed monthly on each unit. The following is analyzed by Health Information Services:

1. Physician Orders:
   a. All orders must be dated, timed and signed by the ordering Physician and noted by the nurse.
   b. Nursing Orders written as ‘NO’ or Nursing order should be signed and noted by a nurse. A telephone order or Verbal orders must be authenticated by the ordering provider and noted by a nurse.
   c. eCW – Medications dispensed by the pharmacy are ordered in eCW. Telephone encounters have to be authenticated by the ordering provider.
   d. Errors – Ask the physician who made the error to draw one line through the error and an initial.
   e. Thinning – Always keep the most recent three months of protected health information, in the rack chart. All thinnings removed from the rack chart should be filed in HIS file room on the unit immediately.
   f. Deficiencies – Tag deficiencies and enter them into the Chart deficiency system at the completion of monthly concurrent analysis. Print out deficiency report and send out to physicians.

2. Admission History and Physical Examination:
   a. History and Physical can be dictated using the following systems: Webmedx, typed directly into LCR (Life time Clinical Record) or typed directly into eCW. There must be a typed and signed H&P in every patient's chart this includes the following
changes in service: SNF to acute and acute to SNF. Acute includes Acute Medical (LAM) and Acute Rehab (LAR). The H&P must contain the following information.

i. Patient and/or decision maker/family has been informed of diagnosis

ii. Rehab potential

iii. TB screening

iv. Discharge Plan

b. Guidelines for H&P Assignment: The H&P is assigned to the physician who admits the patient even if it is not the attending physician. In the absence of the attending physician, the replacement physician (the night/waken physician or the covering physician) would be responsible. This applies to all units including LAM and LAR.

3. Annual Assessment:

a. Annual Assessment can be dictated using the following systems: WebMedX, typed directly into LCR (Life time Clinical Record) or typed directly into eCW.

4. Physician Progress Notes:

a. Physician Progress Notes can be dictated using the following systems: WebMedX, typed directly into LCR (Life time Clinical Record) or typed directly into eCW.

5. Advance Directives

a. Are completed and signed by the physician. Errors – Ask the person who made the error to draw one line through the mistake and initial.

6. Laboratory Reports

a. Laboratory Reports: See LCR (Life time Clinical Record) to see the reports.

7. Radiology Reports: See LCR (Life time Clinical Record) to see the reports.

8. EKG Reports

a. These are to be filed in reversed chronological order. Reports are to be signed by the cardiologist interpreting the report. EKG reports must be corresponded with the stamps in the progress notes.

9. Pathology Reports
a. Pathology reports are done at outside facilities and are filed after the EKG reports in reverse chronological order. They should not be filed in the records from other hospitals. Check the date and medical record number. Reports must be signed by the physician.

b. These reports must be signed by the surgeon who performed the operation. Operative reports are also filed in reversed chronological order.

c. Consent Form - A consent form signed by the patient for performing the operation must be in the chart.

10. Nutrition Screening Form

a. The dietitian documents the initial nutritional assessment on the Nutritional Screening form and places it in the medical record. The dietitian assesses all SNF residents within 14 days of admission. All REHAB residents are assessed within 7 days; ACUTE patients are screened within 72 hours. Residents readmitted within 3 days will be reassessed within 14 days. Exception: Resident is discharged in less than the time allotted.

b. Deficiencies: HIS does not analyze the record for ancillary deficiency.

11. Nursing Admission Assessment

a. There must be one in every chart filed in the nurses’ notes section.

b. Thinning – This form remains in the record permanently.

c. Deficiencies: HIS does not analyze the record for ancillary deficiency.

12. Graphic Record

a. The Graphic Record is filed in chronological order and can also be located in LCR.

b. Blood Pressure – B/P should be done at least once a month unless otherwise ordered.

c. Thinning – Always keep at least the most recent six months in the rack chart and months in the drawer. These thinnings are to be filed immediately if brought up to H.I.S. These thinnings should not be sitting around.

d. Deficiencies: HIS does not analyze the record for ancillary deficiency.

13. Integrated Notes

a. All notes must be signed and dated by the nurse or ancillary provider.
b. Thinning – Always keep at least the most recent three months in the rack chart. These thinnings are to be filed immediately in the HIS file room on the unit. These thinnings should not be sitting around.

c. Deficiencies: HIS does not analyze the record for ancillary deficiency.

14. MDS

  a. 15 months-worth must be filed on the nurses unit at all times.

15. Medication Record and Treatment Record

  a. Medication Record generated from QS1 and HIS.

  b. The time and dose of drug administered to the patient shall be properly recorded in each patient’s medical record by the RN or LVN who administered the drug. All orders must be in writing. Each medication and treatment must be written orders. These records are filed in chronological order in the chart. Treatment records are filed after medication records.

  c. Thinning – Always keep at least the most recent three months in the rack chart and all thinnings should be filed immediately in HIS file room on the unit. These thinnings should not be sitting around.

  d. Deficiencies: HIS does not analyze the record for ancillary deficiency.

16. Weight Record

  a. This form is filed in chronological order. All patients are to be weighed on admission.

  b. Thinning – Always keep at least the most recent three months in the rack chart and three months in the drawer. And all thinnings should be filed immediately in HIS file room on the unit.

  c. Deficiencies: HIS does not analyze the record for ancillary deficiency.

17. Bowel and Bladder Maintenance Program (Back of Nursing Admission Assessment)

  a. The Bowel and Bladder Maintenance Program sheet must be completed within two (2) weeks of admission. This form remains in the patient’s chart permanently.

  b. Thinning – This form remains in the record.

  c. Deficiencies: HIS does not analyze the record for ancillary deficiency.
18. DNCR (DAILY NURSING CARE RECORD)
   a. Thinning – Always keep at least the most recent month in the rack and all thinnings should be filed immediately in HIS file room on the unit.
   b. Deficiencies: HIS does not analyze the record for ancillary deficiency.

19. MDS Interdisciplinary Quarterly Review
   a. All sections are to be completed and signed by the appropriate corresponding discipline. The
   b. Social worker is responsible for completing both the Social Service section and the Patient/Representative section.

20. Therapy Reports
   a. These therapy progress notes include physical therapy, occupational therapy, speech therapy and audiology. They are to be filed in chronological order and are either hand written or typed.
   b. Progress Notes – All progress notes are dated and signed initial.
   c. Initial Evaluation Note – If services are given for physical or occupational therapy, then there should be two initial evaluation notes; one for each service
   d. Deficiencies: HIS does not analyze the record for ancillary deficiency. However Evaluation if needs physician signature assign the deficiency. Thinning – Do not thin therapy reports. These thinnings are never brought up to H.I.S.

21. Activity Section
   a. Initial Assessment – This form heads the activity section and is never removed from the rack chart. It must be completed, dated and signed within seven (7) calendar days from the time of the patient’s admission (does not include transfers). It also requires a full signature, not initials.
   b. 30-Day Assessment/Leisure Interest Survey (located on the back of the Initial Assessment) – Completed in 30 days from date of admission, signed, and dated by the activity therapist.
   c. Annual Assessment/Leisure Interest Survey – Completed one year from the date of admission and every year thereafter. Current annual is retained in the rack chart. It is completed, dated and signed by the activity therapist.
d. Quarterly Progress Notes – These notes must be in the patient’s chart completed, dated and signed within a maximum of three, six, nine months from the date of admission. Quarterly progress notes are filed in chronological order.

e. Respite – Documentation is not required for respite patients. In some cases, attendance records may be kept if a respite patient chooses to participate in activities.

f. Thinnings – The following documents are filed in the rack chart:
   i. Initial assessment
   ii. Current annual assessment and all thinnings should be filed immediately in HIS file room on the unit.

g. Deficiencies: HIS does not analyze the record for ancillary deficiency.

h. Conditions of Admission
   i. The Conditions of Admission which also includes acknowledgement of receipt of Bill of Rights must be signed by the patient. If the patient is unable to sign or refuses to sign, it must be stated on the form and two witnesses must sign. If the patient leaves his mark, two witnesses again must sign the form.

   i. Thinning – This form is never removed from the rack chart.

22. Social Service

   a. Social Service Initial Assessment/Psychosocial Assessment – Each resident must have an initial assessment dated and signed by a social worker within five (5) days of the admission. Acute care – due within 24 hours of admission.

   b. Social Service Semi-Annual Assessment Form – The semi-annual assessment must be completed within 6 months from date of admission.

   c. Annual Assessment – Due one year from date of admission.

   d. Quarterly Progress Assessments – Must be completed by the end of the month in which they are due. The Social Service Semi-Annual Assessment Form will suffice for the progress notes.

   e. Deficiencies – Deficiencies: HIS does not analyze the record for ancillary deficiency.

23. Registration and Admission Record (Face sheet)
a. Each chart must have a face sheet. This form is never removed from the rack chart. This form is occasionally updated with a revision date typed on the top of form. Please review carefully before discarding the old face sheet.

b. Thinning – This form remains in the chart.

c. Deficiencies – Deficiencies: HIS does not analyze the record for ancillary deficiency.

d. Inventory of Patient’s Property
   i. This sheet must be in every patient’s chart. It should be signed by the patient. If the patient is unable to sign or refuses to sign, the form must state this and two witnesses must sign. If the patient leaves a mark, two witnesses again must sign the form. Although the patient may not have any property, this statement should be documented onto the inventory sheet and signed.
   
   ii. Thinning – This form is never to be removed from the rack chart.
   
   iii. Deficiencies: HIS does not analyze the record for ancillary deficiency.

e. Chronological Record Sheet
   i. This form is updated for each admission, transfer to/from, and discharge. A. Thinning – This form is never removed from the rack chart.
   
   ii. Deficiencies: HIS does not analyze the record for ancillary deficiency.

f. Consent Forms/Release Forms
   i. Must be signed by the patient. If the patient is unable to sign, it must be signed by two witnesses.
   
   ii. If the patient leaves his mark, it must also be signed by two witnesses. For example, Refusal to Pay for Laundry or Clothing, Refusal to Participate in Recreational Activities, Refusal to Wear Wrist Band, etc.
   
   iii. Thinning – Do not thin these forms. They are never to be removed from the chart. Also Psychoactive medication form and Aero scout consent form needs to be scanned into Ecw.
   
   iv. Deficiencies: HIS does not analyze the record for ancillary deficiency.

g. Rx for Appliances and Prosthetic Clinic

h. Inter-Facility Transfer Report
i. Blue Cross Physical or Occupational Information
j. Medi-Cal Treatment and Authorization Payment Request
k. Correspondence Information
l. A&D Sheet from SFGH
m. Records from Other Hospital/Facility

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
THINNING OF PROTECTED HEALTH INFORMATION DOCUMENTATION FROM UNIT RACK CHART

POLICY:

Active medical records of all patients shall be thinned routinely or as needed.

PURPOSE:

To maintain an organized clinical record by removing excess protected health information from resident's/patient's current rack chart, which will enable health care professionals' access to the current protected health information of the patient.

PROCEDURE:

1. Only specified documents shall be thinned from the resident's/patient’s rack chart.

2. To guarantee continuity of protected health information,

   a. Guidelines for Thinning - the following protected health information remains in the active rack record:

<table>
<thead>
<tr>
<th>SECTION/FORMS</th>
<th>TIME PERIOD TO REMAIN IN RACK CHART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Orders</td>
<td>Last 3 Months</td>
</tr>
<tr>
<td>Physician Progress Notes</td>
<td>Last 6 Months</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Labs and Diagnostic Reports</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Integrated Progress Notes</td>
<td>Last 3 Months</td>
</tr>
<tr>
<td>Assessments</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Dietary</td>
<td>Initial and last annual</td>
</tr>
<tr>
<td>Social Service</td>
<td>Initial, last semi-annual &amp; annual</td>
</tr>
<tr>
<td>PASARR</td>
<td>Most current</td>
</tr>
<tr>
<td>DMH/DDS Letters</td>
<td>Most current</td>
</tr>
<tr>
<td>Activity Therapy</td>
<td>Initial and last annual</td>
</tr>
<tr>
<td>MDS</td>
<td>Last Annual (Minimum of 15 months on unit)</td>
</tr>
<tr>
<td>Interdisciplinary Meeting Notes</td>
<td>Last 3 Meetings</td>
</tr>
<tr>
<td>Daily Nursing Care Record</td>
<td>1 Month</td>
</tr>
<tr>
<td>Behavioral Monitoring</td>
<td>Last 3 Months</td>
</tr>
</tbody>
</table>
b. Documentation

i. Unauthorized employees will not be allowed to remove protected health information documentation from the rack chart.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
PHYSICIAN ORDER PROCESSING

POLICY:

Health Information Services (H.I.S.) processes physician orders monthly.

PURPOSE:

To provide physicians, nursing and pharmacy with printed physician orders, medication administration orders and treatment records for each resident/patient.

PROCEDURE:

1. The three documents produced:
   a. Physician Orders
   b. Treatment Records
   c. Medication Records

2. Pulling of Physician Orders
   a. Nursing:
      i. Stamps lower left corner of the original physician’s orders (3part NCR) with patient addressograph card so that patient’s name is visible on the form.
      ii. Writes patient’s bed number and allergies on the original physician’s order (3-part NCR) form.
      iii. Check to see if the physician’s order sheet is full. The yellow and pink copies of the orders are to be removed from the medical record and forwarded to pharmacy every day for pick-up by HIS personnel.
   b. Physicians:
      i. Physician completes pre-printed admission orders.
      ii. On 3 part NCR form legibly documents, dates and signs all entries, diagnoses, orders and changes. The 3part NCR form is used as an input/source document.
      iii. Reviews and signs printed orders.
   c. Health Information Services:
i. By 1pm each day, the Physician Order typist or Clerk goes to the Pharmacy and picks-up copies of physician’s orders (two copies of NCR form). The second yellow copy is for HIS and the third pink copy is for Pharmacy.

ii. Pulled orders are taken to HIS Physician Order Processing area, for the separation of the yellow copies from the pink copies. The yellow copies remain in HIS, in the Physician Order Processing area and pink copies are sent to the Pharmacy. The HIS Physician Order Processing clerks sort the yellow copies and place them in the designated Unit sorter trays. Each group of orders are alphabetized by last name, then first name for updating and processing.

iii. The Physician Order Processing typist and clerk are responsible for updating, processing the physician orders, medical records and treatment records using the Clinical Data System on a daily basis

3. Distribution of Printed Orders

a. Health Information Services:

i. Upon completion of the printing of the orders, the processing clerk and typist distributes one (1) set of the physician orders, the treatment records and the medication records to the units.

b. Nursing:

i. The Head Nurse reviews printed orders for accuracy and notifies the processing clerk and typist of any errors by either:

   • Calling the HIS Physician Order Processing area following the delivery to request a corrected copy for the same month or

   • Noting corrections directly onto the Physician Order forms, to indicate a request for a corrected print copy for the next month’s batch or,

   • Completing a special corrections form, by listing all of the patients with Physician Orders that contain errors and what the changes should be. The changes will show on the next month’s batch of Physician Orders.

ii. Nursing will sign on the “Reviewed By” line after reviewing orders.

iii. Nursing will note the orders after the Physician reviews and signs the orders.
c. Physician:

i. Will review, sign and date the new printed Physician Orders that are correct.

d. Health Information Services

i. The Physician Order Processing clerk and typist addresses all calls, inquiries and questions from the units regarding physician order processing.

4. Procedure for Obtaining Physician Orders

a. Physician order sheets are processed daily, each month. The processing should be completed by the last work day of each month. The LVNs and Unit Clerks are responsible for pulling the physician order sheets for each patient in the unit and forwarding all of the physician’s orders to the Pharmacy, where the orders are picked up by either the HIS File clerk, Physician Order Processing Clerk or Typist on a daily basis.

i. On the 19th of each month, the Physician Order Processing Typist or Clerk goes to the units and delivers both blank and new printed physician orders (3-part NCR) to the Nursing staff. The Head Nurse or Nurse Manager is informed that the orders will be pulled that day. The Nursing staff is also reminded that all printed orders must be signed and dated by the Physician before the Physician Orders are removed from the unit. If the orders are signed and dated the Nursing staff will have to forward the orders to HIS the next day or as soon as possible.

ii. Pull the patient’s rack chart and remove the physician orders (3-part NCR form). Remove the following copies yellow and pink from the rack chart. Leave the white copy of the physician orders in the rack chart. If there is any blank space appearing on the Physician Order form, draw a line through the blank area of the page, prior to pulling the yellow and pink copies of the Physician Orders to prevent a Physician from writing any additional orders on the form after the copies have been removed.

- All copies of the Physician Orders should have the yellow and pink copies pulled including: Pass Orders, Enteral Nutrition Orders, Tracheostomy Care Orders, Restraint Orders, Warfarin Orders, and the Anti-Neoplastic/Cytotoxic Medication Orders.

- Remove a copy of the previous month’s printed Physician Orders (processed orders). Keep the previously processed Physician Order copies together with the newly pulled NCR yellow and pink colored copies.
• Make sure that the most complete copy of the printed Physician’s Orders that has the signatures of the Unit Physician, the Nurse and the Pharmacist, remains in the rack chart.

• The printed copy of the Physician Orders is filed by the Unit Clerk or a Nurse, so be sure to look through the orders section of the rack chart to validate that no other copies of the 3-part NCR Physician Orders have been missed.

iii. Reinsert back into the rack chart, the white copy of the written orders in the order they were removed from the patient’s chart. Re-file the patient’s rack chart in the same location on the rack chart holder.

iv. Repeat the steps as outlined above until all of the copies have been removed from each rack chart.

v. Check with the Nurse in charge of that unit for rack charts of residents/patients whose rack charts were not available while you were on the unit. If the rack chart is missing from the rack or not available, look for the addressograph card of missing/unavailable resident/patient chart and write down the name and medical record number and remember to go back to the unit at another time to pull the Physician orders. The Nurse or the Unit Clerk can also forward the remaining physician’s orders to HIS.

vi. Separate the Pharmacy copies from the Health Information Services Physician Order Processing area copies.

vii. Secure the copies with a rubber band (the previous month’s copy of printed order and the yellow and pink copies) and take the copies to the Pharmacy. Be sure that the Pharmacy also gets their copy of the ‘late pulled orders” by either having the Nurse Manager/ Head Nurse send the copies directly to the Pharmacy via interoffice mail or request that someone from the Unit take the copies to the Pharmacy.

viii. The HIS Physician Order Processing Clerk or Typist will sort, batch and then separate the yellow and pink copies that have been picked up from the Units.

ix. Place the yellow copies of each unit in alphabetical order by the resident’s/patient’s last name.

5. Printing Process for: Physician’s Orders, Medication Records and Treatment Records
i. Physician Order Processing Clerk or the Typist prints the physician’s orders, the medication records (MAR) and the treatment records (TAR) after the Physician Orders have been processed, typed and updated for all Units. This process occurs before the end of each month. The sets of Physician Orders are delivered to the units where they are reviewed by the Nursing staff for accuracy, identification of any errors and identification of required corrections. The edited Physician Orders are forwarded to the HIS Department to address the requested edits and correction and re-printing of the corrected Physician Orders.

b. The Admitting Orders and Readmit Orders that were picked up from all of the units, are also processed and printed at the end of each month.

c. The Physician Order’s Clerk or typist will also print the Pharmacy MARs using the QS/1 system that is physically located in the Pharmacy department. The Pharmacy MARs are interfiled by units for delivery with the printed Physician Order sets.

6. Distribution of Physician Orders (3-Part NCR)

a. First copy (white) stays in the resident's/patient’s chart.

b. Second copy (yellow) to H.I.S. for storage in file cabinet.

c. Third copy (pink) to the Pharmacy department.

7. Delivery of Physician Orders

a. The Physician Order’s Clerk or Typist will print all Physician Orders that have been edited, updated and corrected. After the printing has been completed, the Physician Order’s Clerk or Typist will sort the documents, by unit in preparation for delivery.

b. All of the sorted Physician Orders are delivered to the units by either the HIS File clerk, Physician Order Processing Clerk or the Physician Order Processing Typist.

8. Physician Order Processing Correction Requests:

a. A copy of a correction request form is provided to the units, upon request and are completed by the Nursing staff.

b. The correction request form contains the following information: unit name, date requested by the unit and the extension number. The patient name, date or month of the order, corrections/changes to be made and in which area of the form as well
as which type of form [Physician Orders, Medication Orders and/or Treatment Orders].

c. After the corrections have been completed, the Physician Order Processing Clerk or Typist will complete the following items on the form: the date received, corrections completed by whom and the date when the correction is completed.

d. When the requested corrections have been completed, the corrections request form is filed along with the processed orders on each unit, into a filing cabinet located in the HIS Department.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
TRANSCRIBED REPORTS

POLICY:

1. Health Information Services (H.I.S.) provides the following options for Clinicians to produce dictated, transcribed or direct entry typed reports:

   a. A centralized dictation system with transcriptionist on site in the Health Information Services department.
   
   b. Transcription services provided by a transcription vendor that is accessible 24 hours a day, seven days a week.
   
   c. Ability to directly type a report into either the Live Clinical Repository (LCR) or e-Clinical Works (eCW).

PURPOSE:

To support the documentation process associated with quality patient care through accurate transcribed reports.

PROCEDURE:

1. Reports dictated and transcribed shall routinely contain the following information on each report:

   a. Name of hospital
   
   b. Location/Unit
   
   c. Date of Service
   
   d. Medical Record Number
   
   e. Type of report
   
   f. Patient name
   
   g. Date dictated
   
   h. Date transcribed
   
   i. Initials of transcriptionist
   
   j. Signature of dictator
2. Scope of Service
   a. The following reports may be dictated:
      i. History & Physical
      ii. Discharge Summary
      iii. Consultation Reports
      iv. Operative Report
      v. Clinic Notes
      vi. Annual Patient Review
          • Special Reports

3. Authorized Users and Access
   i. Physicians responsible for dictating reports/documents will be authorized to access the dictation system.
   ii. Each authorized dictation user will be provided with general instructions for using the system.
   iii. Access to material dictated but not transcribed is limited to:
       • Transcriptionists only.

4. Processing Time and Priority Designation
   i. All dictation shall be transcribed and placed in the appropriate patient medical record by H.I.S.
       • Personnel.
   ii. The various turnaround times for transcribing are established in recognition of:
       time sensitivity, value of the information for patient care.
   iii. Routine dictation shall meet the turn-around-times.
iv. STAT reports may be dictated and either the outside transcription service or HIS transcriptionist will be notified for immediate transcribing of the dictation. During the HIS Department’s operation hours (6:00 AM to 4:30 PM).

v. Physicians must notify the HIS transcription unit or the outside transcription services prior to dictating any STAT report.

vi. STAT reports dictated after the HIS Department operation hours will be processed immediately at the beginning of the next work day, unless the Physician notifies the transcription service of the STAT report.

vii. The turnaround time for a STAT reports is three (3) hours.

viii. The following types of reports may be considered for STAT work status:

- Discharge summaries for patients being transferred.
- History & Physicals for patients scheduled for surgery.
- Any dictation deemed urgent.

5. Any questions regarding STAT dictations should be referred to the HIS department.

6. Access and Location of Dictation Equipment - Dictation system will be provided on a continuous basis (24 hours a day/seven days a week) via direct telephone access.

   a. A special dictation station is available in the Outpatient Clinic:

7. Reports typed directly into the Live Clinical Repository (LCR):

   a. Clinicians may choose to type their reports directly into the Live Clinical Repository (LCR) System. The clinician will make a notation in the hard copy medical record indicating that the report has been typed into the LCR system.

8. Reports typed directly into the e-Clinical Works (eCW) system:

   a. Clinicians may choose to type their reports directly into the e-Clinical Works (eCW) system. The clinician will make a notation in the hard copy of the medical record referring the viewing to find the report in eCW.

9. Transcription Distribution:

   a. Discharge Summaries:
i. Transcribed discharge summaries are printed on the neighborhood/unit and also in the Health Information Services department at the Physician Completion desk, for all patient types.

Discharge Summaries directly typed into either LCR or eCW will be printed in the Health Information Services department and filed into the hard copy medical record.

b. History & Physical:

i. Dictated and transcribed H&P reports will be printed in the Health Information Services Department and filed into the medical records.

c. Advance Directives

i. Advance Directive report may be dictated and transcribed, or typed directly into the LCR or eCW.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
RECORD REQUESTS

POLICY:

The retrieval of protected health information.

PURPOSE:

To assure that all protected health information is maintained and easily accessible to the Health Information Services department personnel, medical staff and other health providers authorized to access/use the protected health information.

PROCEDURE:

1. Retrieval of Protected Health Information

   a. Protected Health Information (PHI) of discharged patients must be received by the Health Information Services Department within 48 hours of discharge in order for Health Information personnel process the record.

   b. Protected Health Information (PHI) of discharged patients include the contents of the rack chart, thinned protected health information, and any other loose documents associated with the patient’s stay and services.

2. Chart Requests

   a. The Health Information Services Department must be notified one (1) day in advance for any chart requests. Requests for same-day deliveries are accepted if the call is made by 8:00 a.m. Charts will not be delivered outside of the scheduled delivery time, unless caller identifies the request as an emergency or STAT chart request. Health Information personnel are available on weekdays between the hours of 8:00 a.m. - 5:00 p.m.

   b. All charts requested from the Health Information Services Department must be returned within 72 hours.

   c. When 10 or more records are requested for, i.e., special studies, audits, etc., the “Request for Health Information Special Studies” form must be completed and submitted to the Health Information Services department one (1) week prior to the requested date.
ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to comply with the Department of Public Health's (DPH) policy, “Authorization for Use and Disclosure of Protected Health Information: (See Appendix A). It is also the policy to have the resident/patient or resident complete the appropriate form in order to authorize the disclosure and/or use of individually identifiable health information (see Appendix B-1 and B-2).

2. DPH Policy: Authorization For Use And Disclosure Of Protected Health Information:
   a. It is policy of the San Francisco Department of Public Health (DPH) to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other applicable state and federal confidentiality laws by obtaining authorization before using or disclosing protected health information (PHI), unless the use or disclosure is specifically permitted or required by law.
   b. This policy pertains to all individuals who have access to, use, or disclose Department of Public Health PHI. DPH divisions or units may enforce stricter authorization requirements for the use or disclosure of PHI than those set forth in this policy.

PURPOSE:

1. To uphold the confidentiality of Health Record Information and protect the individual’s right to privacy in the collection and disclosure of protected health information (PHI) in accordance with:
   b. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996
   c. Department of Public Health’s (DPH) policy.
   d. Any other federal and state statutes which provide additional protection for certain medical, mental health and substance abuse information.
   e. In situations where laws conflict or overlap, the law that provides the resident/patient with the greater protection will take precedence.

DEFINITIONS

1. Protected Health Information (PHI): Individually identifiable health information maintained or transmitted in any medium.
2. Use: The sharing, employment, application, utilization, examination, or analysis of protected health information within DPH, its affiliates, or its contract providers.

3. Disclosure: The release, transfer, provision of access to, or divulging in any other manner of protected health information.

4. Authorization: The formal consent document releasing PHI from the records of an entity covered by the privacy provisions of HIPAA.

PROCEDURE:

1. Minimum Necessary Rule
   a. General Rule: When disclosing PHI, or when requesting PHI from another covered entity, providers must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
   b. Exceptions
      i. Disclosures for, or uses related to, treatment (see Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes
      ii. Uses or disclosures made pursuant to a valid HIPAA authorization which describes the PHI to be disclosed;
      iii. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to an investigation or compliance review; and
      iv. Other uses or disclosures that are required by law and that commonly prescribe what information must be disclosed (e.g., pursuant to a subpoena or court order, reporting child abuse or any other use or disclosure of PHI that is required by law).

2. Administration of Authorizations
   a. An authorization is required in the following situations (see Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes):
      i. Per the HIPAA Privacy Rule for use of PHI by DPH, its providers, its affiliates and its contract providers for purposes not related to treatment, payment or health care operations.
      ii. Per 42 CFR Part 2, for the disclosure of information pertaining to an individual’s treatment in a substance abuse program, except in a medical emergency.
iii. Per DPH Policy, for the disclosure of information pertaining to sexually transmitted disease treatment from the DPH City Clinic (Municipal STD Clinic) or other communicable disease treatment by DPH Community Health Epidemiology when not related to infectious disease monitoring procedures.

iv. Per CCSF Local Share Mandate established with the California Office of AIDS, for the disclosure of information pertaining to an individual’s treatment in a CCSF HIV Health Service program outside that network of providers.

b. Valid Authorization Forms

i. When authorization is required, all DPH divisions/units and providers shall obtain resident/patient/client/resident authorization using the standard DPH Authorization to Release Protected Health Information form.

ii. Due to strict HIPAA requirements for an authorization form to be valid (see Attachment B), any DPH provider that plans to develop a different authorization form must have that form approved by a DPH Privacy Officer.

iii. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be returned to the sender.

iv. All researchers who request permission to conduct a study with human subjects in the DPH must include with the request a DPH standard authorization for the use of the PHI generated from the study. This standard authorization must contain all elements required by HIPAA. Refer to DPH Privacy Policy “Conduct of Research” for more information.

c. Invalid Authorizations

i. An authorization is not valid if:

- The expiration date has passed or the expiration event is known by DPH to have occurred;
- The authorization has not been filled out completely;
- The authorization is known by DPH to have been revoked;
- Material information in the authorization is known by the DPH to be false;
- The authorization was improperly combined with another document; or
• The authorization is not in 14-point font type.

d. Documenting Authorizations

i. All authorizations for use and disclosure of DPH PHI should be filed in the correspondence section of the medical record of the individual concerned.

ii. A copy of the completed authorization form should be offered to the resident/patient.

e. Compound Authorizations

i. General Rule: DPH authorizations may not be combined with any other document to create a “compound authorization.”

ii. Exception: An authorization for the disclosure of DPH PHI generated by research may be combined with the required informed consent for participation in the research.

f. Making Treatment, Payment, Enrollment, or Eligibility Conditional Upon an Authorization

i. General Rule

• DPH shall not make treatment, payment, enrollment in a health plan or eligibility for benefits conditional upon the resident/patient, resident or client’s execution of an authorization.

ii. Exceptions

• For treatment as part of research in which the individual will participate as a human subject.

• When the purpose is to create DPH PHI to disclose to a third party (e.g., pre-enrollment physicals).

• When the program is designed for a specific population whose participation is conditional upon authorization (e.g., Behavioral Health Court).

• A DPH-sponsored or DPH-affiliated health plan may make enrollment or eligibility for benefits conditional upon authorization, provided that the authorization (i) is obtained prior to enrollment and (ii) relates specifically to the individual or to underwriting or risk-rating determinations.
3. Oral Agreements

   a. DPH may rely upon an individual’s oral approval to disclose, restrict or prohibit the use of PHI under the following circumstances:

      i. For an resident/patient facility directory;

      ii. For involvement in the individual's care by next-of-kin, family members, domestic partners and/or close personal friends; and

      iii. To notify a family member, personal representative or other person responsible for the care of the individual about the individual’s location, general condition or death.

4. Minors

   a. Parent or Legal Guardian must authorize uses or disclosures of a Minor's PHI, unless Minor is:

      i. Emancipated (Married, Active Military Service, By Court Order); or

      ii. Self-Sufficient (age 15 or older, living separate and apart from parents, managing own finances) if relative to General Medical and Dental Care; or

      iii. By law, is allowed to give own consent to "Sensitive Services." Criteria for that includes:

          - Any Age Minor: Care related to the prevention or treatment of pregnancy, sexual assault or rape,

          - Minor age 12 and older: resident/patient mental health (if "at risk" criteria are met), resident/patient drug and alcohol, treatment of infectious, contagious or communicable reportable disease or sexually transmitted disease, HIV testing and treatment.

5. Deceased Residents/Resident/Patient

   a. For deceased residents/patients, the resident/patient representative (next of kin or executor of estate) has the rights that the resident/patient would have had relative to access and release of the record.

6. Employment Determinations

   a. Authorization is required for DPH to use or disclose an individual’s PHI for employment determinations. For example, DPH must have the individual’s
authorization to disclose the results of a pre-employment physical to an individual’s employer.

7. Verification Procedures

a. Prior to making any disclosures permitted by HIPAA, staff shall verify the identity of the person requesting DPH PHI and the authority of any such person to have access to DPH PHI.

8. Media and Other Inquiries

a. All media inquiries should be referred immediately to a DPH Privacy Officer and/or the DPH Public Information Officer prior to release of information.

b. No information may be disclosed if the resident/patient has requested that information be withheld. Otherwise, the condition of a resident/patient to the media may be disclosed only if the inquiry specifically contains the resident’s/ patient’s name. (See exclusion in F and G below.)

c. A DPH resident’s/patient’s condition may be described only in general terms that do not communicate specific medical information about the individual (e.g., undetermined, good, fair, serious, critical, or deceased).

d. Care should be taken to first notify the DPH resident’s/patient’s next of kin before the fact of death is made public. No additional information about a resident’s/patient’s death, including the cause, date, or time of death, may be made without written authorization from a legal representative of the deceased resident/patient, even if this information has been disclosed to the Medical Examiner or the Death Registrar.

e. Information concerning a DPH resident/patient’s location in the hospital may be made to facilitate visits by family or friends or for delivery of gifts or flowers if the inquiry includes the resident’s/patient’s name and there is no instruction from the resident/patient to withhold such information. This information should not be routinely disclosed to the media.

f. Information may not be released to the media about identifiable DPH resident/patient engaged in behavioral health services (including those served in outreach, mental health, substance abuse, HIV, or supportive housing programs). This policy applies to current, previous, and deceased residents/patients and to cases even when the resident/patient has requested or authorized DPH staff to speak to the media.

g. Per DPH policy, brochures or publications developed by DPH-funded programs are not to include identifiable residents/patients in photos or personal stories that
disclose their current or past mental health issues or substance use, or engagement in behavioral health services. This policy applies to current, previous, and deceased residents/patients and to cases even where the resident/patient has requested or authorized DPH staff to present them in publications.

9. Permissible Disclosures Without Authorization for Public Policy Purposes

a. An authorization is not required in the following situations:

i. For disclosures required by state or federal law.

ii. For DPH public health activities specifically permitted or required by law, such as preventing and controlling disease, injury, or disability; providing information to the Food and Drug Administration regarding adverse drug events, tracking health-related products, enabling product recalls, or conducting post-marketing product surveillance.

iii. For a work-related injury or illness when the release is to the responsible employer (the individual must be informed of the disclosure); that is, the employer has sent the resident/patient, is paying for the care under workers comp, etc.

iv. For reporting victims of abuse or neglect as specifically required under the law.

v. For reporting to a health oversight agency regarding activities authorized by law, including civil, administrative or criminal investigations, proceedings, actions, or inspections, audits, licensure surveys or investigations, or disciplinary actions.

vi. For responding to an order of a court or administrative tribunal issuing a subpoena, discovery request or other lawful process.

vii. For providing the San Francisco Medical Examiner or a funeral director with information needed to carry out his or her duties as authorized by law.

viii. For facilitating organ, eye, or tissue donation and transplantation.

ix. For preventing or lessening a serious and imminent threat to the health or safety of a person or the public when the individual to whom the disclosure is made is capable of preventing or lessening the threat.

x. To warn reasonably identifiable victim(s) and notify law enforcement when a resident/patient communicates a serious threat of violence against a reasonably identifiable victim or victims (Tarasoff Duty to Warn).
xi. For informing the Department of Veterans Affairs as authorized by law of information needed for determination of eligibility or entitlement to benefits for an individual following discharge from military service.

xii. For disclosing information as authorized by law to provide benefits for work-related injuries and illnesses.

10. Permissible Disclosures Without Authorization for Care Coordination Purposes Not Otherwise Covered

a. As of January 1, 2009, if a minor is a dependent or ward of Juvenile Court, a general health care provider (Civil Code 56.103) or mental health care provider (W&I Code 5328.04) may disclose protected health information to a County social worker, probation officer or other adult who has care and custody of a minor in order to coordinate health care services and treatment (e.g., information about appointments, treatment plans, follow-up care, etc.).

11. Permissible Disclosures of General Health Information Without Authorization for Law Enforcement Purposes

a. An authorization is not required in the following situations:

i. When the disclosure of PHI is made in response to a law enforcement official’s request for such information for the purpose of IDENTIFYING or LOCATING a suspect, fugitive, material witness, or missing person and the PHI is limited to:

- Name and address
- Date and place of birth
- Social Security number
- ABO blood type and Rh factor
- Type of injury
- Date and time of treatment
- Date and time of death, if applicable
- Description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos
b. PHI related to an individual’s DNA, DNA analysis, dental records, or typing, sampling, or analysis of body fluids or tissues MAY NOT be disclosed, excluding ABO blood type and Rh factor.

c. When the disclosure of PHI is made in response to a law enforcement official’s request for such information about an individual who is or is suspected to be a victim of a crime, provided that:

i. The law enforcement official represents that immediate law enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure, and

ii. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred and such information is not intended to be used against the victim.

d. When the disclosure is made to a law enforcement official about a decedent suspected to have died as the result of criminal conduct, excluding Mental Health clients (unless in a state hospital).

e. When the disclosure is made to a law enforcement official about an individual, the PHI of whom constitutes evidence of criminal conduct that occurred on the premises of DPH.

f. When the disclosure is made to a law enforcement authority to identify or apprehend an individual because of a statement made by the individual admitting participation in a violent crime that caused serious harm to a victim, excluding mental health information.

g. When the disclosure is made to a law enforcement authority where it appears from all circumstances that the individual has escaped from a correctional institution or from lawful custody.

h. When the disclosure is made to a correctional institution or law enforcement official having lawful custody of an inmate or other individual for:

i. The provision of healthcare to such individual (disclosures may include mental health or HIV information as well);

ii. The health and safety of such individual or other inmates;

iii. The health and safety of the officers or employees or of others at the correctional institution;
iv. The health and safety of individuals and officers responsible for the transport or transfer of inmates from one correctional or health care setting to another;

v. Law enforcement on the premises of the correctional institution; or

vi. The administration and maintenance of the safety, security, and good order of the correctional institution.

12. Special requirements for mental health and developmental disability information, substance abuse information, sexually transmitted disease information, and health information of minors

a. Mental Health Information

i. Although the federal privacy rule largely does not make a distinction between medical and mental health information, California state law does provide special protections for mental health information. Mental health information may be shared among DPH providers and contractors for the purposes of treatment. All other uses and disclosures require the specific authorization of the patient to disclose mental health information.

ii. Mental health information includes psychotherapy notes, medication prescription and monitoring, counseling session start and stop times, modalities/frequencies of treatment, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis, or progress recorded by mental health professionals.

iii. Generally, disclosures of mental health information require the specific authorization from the patient for release. The state law that addresses the confidentiality of mental health information is the California Welfare and Institutions Code Section 5328 et seq., known as the Lanterman-Petris-Short Act ("LPS Act"). Questions regarding the use or disclosure of mental health information should be referred to the DPH Privacy Officer.

b. Substance Abuse Information

i. Although the federal Privacy Rule does not make a distinction between medical and substance abuse information, other federal statutes and California state laws do provide statutory restrictions for the release of information developed or obtained in the course of providing substance abuse treatment in federally funded substance abuse programs. Substance abuse treatment provided in the course of general medical treatment is not subject to these provisions. Therefore, substance abuse information may be shared among DPH providers and to its contracted providers without authorization of the patient for patient care purposes. For example, substance abuse treatment information may be
shared from the General Medical Clinic to Castro-Mission Health Center or to a substance abuse provider contracted by Community Programs. However, the contracted substance abuse provider must obtain the patient’s authorization to share information back to the General Medical Clinic or Castro-Mission Health Center. All other uses and disclosures require specific substance abuse authorization from the patient.

ii. Information pertaining to substance abuse patients is subject to special protection under federal statute 42 U.S.C. Section 290dd-2 and under federal regulations found in the "Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 C.F.R. part 2. Additionally, California Health and Safety Code Section 11977 provides special protections to information of certain drug abuse programs. The LPS Act may also apply if the patient receives services such as involuntary evaluation and treatment because the patient is gravely disabled or dangerous to self or others as a result of abuse of alcohol, narcotics or other dangerous drugs.

iii. These federal and state statutes require written authorization for disclosure of substance abuse information in certain circumstances and other special protections for substance abuse information. In these situations, the state law must be followed. Questions regarding the use or disclosure of substance abuse information should be referred to the DPH Privacy Officer.

c. Sexually Transmitted Diseases and HIV/AIDS Information

i. Per state law HIV test results cannot be disclosed without specific, written authorization from the patient except for purposes of diagnosis, care, or treatment of the patient by DPH providers.

ii. Per DPH policy, PHI from City Clinic (Municipal STD Clinic) and Community Health Epidemiology unit is only disclosed upon the specific authorization of the patient when not used for communicable disease monitoring and reporting purposes.

ATTACHMENT:
Appendix A: DPH Policy- "Authorization for Use and Disclosure of Protected Health Information"
Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes
Appendix B-1: Authorization to Disclose Health Information
Appendix B-2: Authorization to Disclose Health Information Psychotherapy Notes
Appendix C: Sharing Public Health Information for Treatment Purposes
Appendix D. Required Elements of an Authorization to Release Protected Health Information Form
REFERENCE:
21-04 HIPAA Compliance
21-01 Medical Records Information: Confidentiality and Release

Original adoption: 15/11/09
ACCESS TO HEALTH RECORDS BY OMBUDSMAN

POLICY:

The goal of the State Long-Term Care Ombudsman Program is to advocate for the rights of all residents of long-term care facilities. The Ombudsman’s advocacy role takes two forms: 1) to receive and resolve individual complaints and issues by, or on behalf of, these residents; and 2) to pursue resident advocacy in the long-term care system, its laws, policies, regulations, and administration through public education and consensus building. Residents or their family members can file a complaint directly with the local Long-Term Care Ombudsman or by calling the CRISIS line.

The Office of the Ombudsman does not conduct formal investigations; does not change rules, policies, or procedures; does not participate in any formal hearing or grievance process; does not supersede the authority of other CDCR officials; does not disclose and may not be required to disclose information provided in confidence, except to address an imminent risk of serious harm where there is no other responsible option; and does not engage in any activity that might be perceived by others as advocacy for any individual.

The Office of the Ombudsman listens, answers your questions, analyzes your situation, explains CDCR policies and procedures, advocates for the fairness of a process as opposed to advocating for an individual party, provides information and at times advice and develops options, suggests appropriate referrals, apprises administration of significant trends and may recommend changes in policies and procedures.

Representatives of the Ombudsman office shall have the right of access to both the patient and to the patient’s health record in long-term care facilities for the purpose of hearing, investigating and resolving complaints of, and rendering advice to, elderly individuals who are patients or residents of the facilities at any time deemed necessary and reasonable by testate Ombudsman to carry out the provisions of this chapter.

[California Welfare and Institutions Code, Section 9724: Notwithstanding Section 56 of the Civil Code, in order for the office to carry out its responsibilities under this chapter, the office shall have access to the medical or personal records of a patient or resident of a long-term care facility that are retained by the facility, under the following conditions: (a) If the patient or resident has the ability to write, access may only be obtained by the written consent of the patient or resident. (b) If the patient or resident is unable to write, oral consent may be given in the presence of a third party as witness. (c) If the patient or resident is under a California guardianship or conservatorship of the person that provides the guardian or conservator with the authority to approve review of records, the office shall obtain the permission of the guardian or conservator for review of the records, unless any of the following apply: (1) The existence of the guardianship or conservatorship is unknown to the office or the facility. (2) The guardian or conservator cannot be reached within three working days. (3) The office has reason to believe the guardian or conservator is not acting in the best interests of the ward or the conservatee. (d) If the patient or resident is unable to express written or oral consent]
and there is no guardian or conservator, or the notification of the guardian or conservator is not applicable for reasons set forth in subdivision (c), inspection of records may be made by full-time state employees of the office ombudsman coordinator, and by ombudsmen qualified by medical training and with the approval of the ombudsman coordinator or the State Ombudsman, when there is sufficient cause for the inspection. The licensee may, at his or her discretion, permit other representatives of the office to inspect records in the performance of their official duties. Copies may be reproduced by the office. The licensee and facility personnel who disclose records pursuant to this subdivision shall not be liable for the disclosure. If investigation of records is sought pursuant to this subdivision, the ombudsman shall, upon request, produce a statement signed by the ombudsman coordinator authorizing the ombudsman to review the records. (e) Facilities providing copies of records pursuant to this section may charge the actual copying cost for each page copied. (f) Upon request by the office, a long-term care facility shall provide to the office the name, address, and telephone number of the conservator, legal representative, or next-of-kin of any patient or resident).

The ombudsman seeking access may be either an employee of the office or a volunteer who has not had any special medical training.

**PURPOSE:**

1. To comply with current California and Federal law

2. Access to records includes both the right to inspect original records and the right to obtain copies.

**PROCEDURE:**

1. The ombudsman shall have access to the medical or personal records of a patient or resident of a long-term care facility which are retained by the facility, under the following conditions:

   a. If the patient or resident has the ability to write, access may only be obtained by the written consent of the patient or resident.

   b. If the patient or resident is unable to write or sign, oral consent may be given in the presence of a third party as witness, i.e., not the person to whom consent is being given.

   c. If the patient or resident is under a California guardianship or conservatorship of the person, which provides the guardian or conservator with the authority to approve review of records, the office shall obtain the permission of the guardian or conservator for review of the records, unless any of the following apply:
i. The existence of the guardianship or conservatorship is unknown to the office or the facility.

ii. The guardian or conservator cannot be reached within three working days.

iii. The office has reason to believe the guardian or conservator is not acting in the best interest of the ward or the conservatee.

2. Processing Copies of Protected Health Information

a. Upon receipt of an authorized written request:

   i. Locate record

      • If record cannot be located after 72 hours.

      • Seek the assistance of other HIS employees in locating the medical record.

      • If still unable to locate the record, send a notice to the requestor that there is a delay in complying with the request, due to record unavailable.

      • Enter information into the Release of Information module of the Clintegrity system and document that contact was made to the requestor, the requestor's name and the date.

   ii. When the medical record is located, document this information into the Clintegrity Release of Information module.

   iii. Verify that signature on the request matches signature in chart or, in the case deceased, the beneficiary or next of kin should match that which is in the chart. Conservators or guardians should send a copy of their appointment papers when requesting copies. Since psychiatric conservatorship must be renewed annually, check to make sure that the appointment is currently active and valid.

b. Ascertain the type of record being requested and referred to separate section of procedures if record is of the below listed types. If standard chart, proceed to step C.

   i. Minor patient – see 13.01; Section V.

   ii. Mental Health Patient – see 13.07
iii. Alcohol and Drug Abuse Patient – see 13.08

c. Notify the Attending Physician or Psychologist of written requests from former
and forward the chart for review before access is granted.
   i. If the Attending Physician denies access, refer to Access Denied process.

   ii. If the Attending Physician elects to provide a summary, refer to procedures,
        Summary Alternative.

d. Copy requested documents from the medical record:
   i. Enter information into Clintegrity’s Release of Information module.

   ii. File the authorization form in the resident’s medical record.

e. When payment is received
   i. Mail copy of the medical record to the requestor by certified mail.

3. Processing Requests for Access to Records

   a. Upon receipt of an authorized written request:

      i. Locate record

         • If record cannot be located after 72 hours. Seek the assistance of other
           HIS employees in locating the medical record.

         • If still unable to locate the record, send a notice to the requestor that there
           is a delay in complying with the request, due to record unavailability.

         • Enter requestor information into the Release of Information module of the
           Clintegrity system and document that contact was made to the requestor,
           the requestor’s name and the date.

         • When the medical record is located, document this information into the
           Clintegrity Release of Information module.

      ii. Verify that signature on the request matches signature in chart or, in the case
           of a deceased patient, the beneficiary or next of kin should match that which
           is in the chart. Conservators or guardians should send a copy of their
           appointment papers when requesting copies. Since psychiatric
           conservatorship must be renewed annually, check Ascertain the type of
           record being requested and refer to the separate section of procedures if
           record is of the below listed types. If standard chart, proceed to step C.
• Minor patient – see 13.01; Section V

• Mental Health Patient – see 13.07

• Alcohol and Drug Abuse Patient – see 13.08

iii. Notify the Attending Physician or Psychologist of written requests from former and forward the chart for review before access is granted.

• If the Attending Physician denies access, refer to Access Denied process.

• If the Attending Physician elects to provide a summary, refer to procedures, Summary Alternative.

iv. If access is authorized by the Medical Director:

• Send letter to requestor – Acknowledgment of Request for Inspection.

• Enter remaining information into the Clintegrity Release of Information Module.

• File a copy of the authorization form into the patient’s medical record.

• Place a copy of Access to Patient Record Form in chart.

• Remove from chart:
  • Material not pertaining to the resident.
  • Information given in confidence.
  • Material not specified in the written authorization.

• When patient or representative arrives to review record:
  • Collect payment (money order).
  • Request signature(s) on Access to Record Form.
  • Request and verify resident’s or representative’s identification with photograph (e.g. driver’s license).
  • Pull the record.
• Stay with resident or representative during review.

• If copies are requested provide the requestor with the request for the copies, log the request into the Clintegrity system, inform the requestor when the copies will be available for pick-up or when the copies will be mailed (within 15 calendar days), and make the copies.

4. Procedure When Access Denied

a. Under HIPAA, if a provider denies access, in whole or in part, it must give the individual a written notice (within five working days, as required by California Law) including the following information:

i. An explanation of the basis for the denial.

ii. A description of how the individual may complain to the provider or to the Secretary of DHHS. The description of to complain to the provider must include the name or title and phone number of the contact person or office responsible for handling privacy complaints; and

iii. If applicable, an explanation of the patient’s review rights and how to pursue those rights [45 C.F.R. Section 164.524(d) (2)].

iv. If access is denied because the Attending Physician has opted to dictate a summary of the medical record, refer to Summary Alternatives.

v. The Attending Physician will make the decisions of denial of access and will inform H.I.S. of this decision. The requestor and/or resident will be notified of denial of access to records.

vi. Denial of access must be noted in the resident’s medical record, including the date of the request, the reason for adverse or detrimental consequences to the resident if the resident was permitted access.

b. Ascertain reason for denial (refer to specific guidelines for the following):

i. Minor Resident, 16.16.

ii. Mental Health Patient 16.17 – Applies to mental health records and also applies to psychotherapy notes not separately maintained or otherwise not meeting the HIPAA definition of psychotherapy notes [Section A “Psychotherapy Notes,” page 15.24; California Hospital Association, Consent Manual 2015.
iii. Alcohol and Drug Abuse Patient, 16.18

iv. X-Ray 16.19

c. Enter information into Clintegrity Release of Information Module and note the reason for denial. If denial does not meet one of the above criteria, contact the Physician who issued the denial of access and document the Physician’s name and reason for denial into the Clintegrity ROI module.

d. Notification of denial must be made within the time frame detailed for each of the following: Denial to access – five (5) working days.

i. Denial to copies – fifteen (15) calendar days.

5. Summary Alternative

a. Health & Safety Code 1795 [this code pertains to Chapter 12. Family Notification... make reasonable efforts to contact the person named in the resident’s admission agreement as the resident’s contact person or the resident’s responsible person, within 24 hours after a significant change in the resident’s health... nothing to do with a summary] permits a provider to furnish a summary of the patient record with the patient’s agreement as an alternative to providing access to the actual record. [Section 25256...this pertains to Division 20. Miscellaneous Health and Safety Provisions, Article 14. Green Chemistry section 25256...nothing to do with a summary].

b. Per the HIPAA Privacy Rule, Department of Health & Human Services: Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity’s designated record set.55 The “designated record set” is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider’s medical and billing records about individuals or a health plan’s enrollment, payment, claims adjudication, and case or medical management record systems.56 The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.

i. CONTENTS: The provider may consult with the patient or patient’s legal representative in order to clarify the purpose in requesting the records. If the
patient request information about certain illnesses, injuries, or episodes only, the summary may be confined to those portion of the record. The summary must include for each injury, illness, or episode covered, any information in the medical record relative to the following

- chief complaint or complaints, including pertinent history;
- findings from consultations or referrals to other health care providers;
- diagnosis, where this has been determined;
- treatment plan and regiment;
- progress of the treatment;
- prognoses, including significant continuing problems or conditions;
- reports of pertinent diagnostic procedures and tests;
- discharge summaries
- objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests;
- current medications prescribed, including dosage and any sensitivities or allergies to medications prescribed;

ii. In some cases, the discharge summary which summarizes each episode of hospital care will meet these requirements, but it should not be used as the summary alternative without a careful review to be certain that it does, in fact, include all of the required information.

c. Allowable Time and Charges: Summaries must be provided within ten (10) working days in which to prepare the summary in two situations:

i. The record is lengthy (because there has been multiple admissions or the care has involved numerous tests or special care); or

ii. The patient has been discharged within ten (10) calendar days prior to the receipt of the request.

iii. The amount charged for the summary will be based on the amount of time spent by the physician and medical records staff in completing the record summary.
d. X-Rays and Tracings: Health care providers are not required to furnish copies of x-rays or tracings derived from electrocardiography, electroencephalography or electromyography, if the original x-rays or tracings are transmitted to another provider within fifteen (15) days after the receipt of a valid written request. Since such tracings are usually voluminous, it is suggested that the provider confer with the requesting party to determine whether copies, a reasonable charge which does not exceed actual cost may be made, without reference to the maximum charge specified for other copies [Section 25252(a)].

i. The law does not address the issue of the provider’s responsibility when the patient or representative declines to name another provider to receive x-rays or tracings and the provider does not have the equipment for making such copies. In some cases, it may be possible for the hospital to arrange to have these special items reproduced by another hospital or copy service in the area. If such an arrangement is not feasible, the provider’s good faith offer to transmit the originals to another provider probably meets the intent of the law and would be considered acceptable compliance.

ii. Refer all requests for x-rays to the Radiology Department.

- Patient Currently Residing at LHH
  - Allow patient to read his/her chart only if the attending physician is present to explain the medical information and to prevent any misunderstanding in reading the chart.
  - Pull chart and forward to attending physician.
  - If a copy/copies are requested.
  - Payment must be made by check or money order only.
  - Make a notation in the register.

- State Personnel
  - Use same procedure as for the Ombudsman.

- Attorney/Client
  - Arrange a date and time for the attorney/client to examine the record.
  - Pull the chart from either the file room or the unit and remove all miscellaneous correspondence, subpoena, etc.
• One hour is the allowed time for review.

• A Medical Record Technician must supervise the review.
• If copies are requested the charge will be determined by the number of pages ($0.25 per page) and $15. Copying fee.
  (i) Payment must be made by check only.
  (ii) Make a notation in the register.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/09
ACCESS TO HEALTH RECORDS

POLICY:

The resident or resident’s legal patient representative shall have access to current Protected Health Information of the resident, within five days after submitting a written request (excluding weekends or holidays) according to Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and the California Health and Safety Code Section 123100 – 123149.5.

PURPOSE:

1. To allow residents the right review their protected health information.
2. To comply with current HIPAA Rules, California and Federal laws.

PROCEDURE:

1. Responding to Requests from Residents and Patient Representatives
   a. Monday to Friday, 9:00 a.m. to 4:00 p.m., except holidays: contact Health Information Services.
      i. Request that the resident complete the Authorization for Release or Disclosure of Protected Health Information Form; Appendix B-1).
      ii. See “Responding to Verbal Requests” section below, if the resident refuses to sign the Authorization Form.
      iii. Make contact with Unit and have the Nurse Manager to notify Health Information Services when the resident is available to review their PHI.
   b. Per Health & Safety Code Section 123100: The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided.
   c. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient’s condition and care. It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.
   d. Pursuant to Health & Safety Code Section 123110:(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections
123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available.

e. “Patient representative” means (1) a parent or guardian of a minor who is a patient, (2) the guardian or conservator of the person of an adult patient, (3) an agent as defined in Section 4607 of the Probate Code, to the extent necessary for the agent to fulfill his or her duties as set forth in Division 4.7 (commencing with Section 4600) of the Probate Code, (4) the beneficiary as defined in Section 24 of the Probate Code or personal representative as defined in Section 58 of the Probate Code, of a deceased patient.

f. However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient’s representative requesting the inspection, who may be accompanied by one other person of his or her choosing. (b) Additionally, any patient or patient’s representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents ($0.25) per page or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The health care provider shall ensure that the copies are transmitted within 15 days after receiving the written request.

g. Family, Close Friends, and Surrogate Decision Makers. Family members or close personal friends of a resident who are not patient representatives as defined above, do not have the right to inspect a resident’s medical record. However, pursuant to Civil Code Section 56.1007 (a), a health care provider may disclose to a family member, other relative, domestic partner, or a close personal friend of the patient, or any other person identified by the patient, the medical information directly relevant to that person’s involvement with the patient’s care. If the resident is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the resident’s incapacity or an emergency circumstance, the health care provider may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the resident and disclose only the medical information that is directly relevant to that person’s (i.e. surrogate decision-maker’s) involvement with the resident’s health care.

2. Responding to Verbal Requests
a. Explain to resident or their legal representative that a written request is required. Use of the Hospital Form “Authorization for Use or Disclosure of Protected Health Information” is required. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be returned to the sender. Access is given no later than five days of receipt of the request.

i. If a copy/copies are requested, the copies will be charged at the current rate per page.

ii. Payment must be made by check or money order only.

iii. Complete the required screens in the Release of Information module of the HIS Nuance Clintegrity System.

b. State Personnel

i. Use same procedure as for the Ombudsman.

c. Attorney/Client

i. Arrange a date and time for the attorney/client to examine the record.

ii. Only authorized H.I.S. staff must supervise the review.

iii. If copies are requested, the charge will be determined by the number of copies at the current rate per page. Payment must be made by check only.

iv. Complete the required screens in the Release of Information module of the HIS Nuance Clintegrity System.

3. Processing Requests for Copies of Protected Health Information

a. Upon receipt of an Authorization for use or disclosure of PHI:

i. Enter the requestor’s information into the Release of Information module of the HIS Nuance Clintegrity System.

ii. Locate record

• If record cannot be located after 48 hours, check the chart locator module to find out who was the last person the record was signed out to. Contact the individual to return the record to HIS.
• Place a copy of the Authorization for use or disclosure of PHI form in the resident’s medical record.

• When payment is received
  • Copy the requested pages of PHI.
  • Enter any remaining information into the HIS ROI module.
  • Mail copy by certified mail to requestor.
  • Not permit.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 15/11/10
EMPLOYEE DEVELOPMENT FUND

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) may accept and will manage monetary donations that are earmarked for employee development according to the intentions of donors.

2. Only donations that are specified for use towards employee development, education and training can be accepted into this fund.

3. Whenever possible, donors shall be encouraged to specify the focus of employee development for which donated funds are to be used (e.g. quality improvement, skill building, employee wellness, etc.).

4. Items that are paid by monies from the Employee Development fund are limited to training resources used to educate employees to improve themselves (e.g. trainer/training fees, books, CDs, DVDs, and other materials used for training purposes).

5. Acceptance and expenditure of donations shall be documented according to City procedures.

6. An Employee Development Fund Management (EDFM) Committee shall be established to review requests for funding and provide recommendations to the Executive Committee to approve or not approve expenditure requests for employee development activities.

7. Individual staff members or a group of staff benefitting from training opportunities paid for from the fund are required to share the benefits of the training through in-service presentations and/or making training materials available to other staff.

PURPOSE:

1. To honor the intentions of donors and to provide education and training opportunities for staff.

2. To assure that the acceptance and expenditure of donations earmarked for staff development meet the specific requirements of the DPH Grants Office as well as the specific requirements of the Health Commission, Board of Supervisors, Controller, and City Attorney.

3. To optimize the use of the funds to benefit as many employees who are interested in enhancing their knowledge, skills and self-development.
PROCEDURE:

1. Donations equal or greater to ten thousand dollars ($10,000.00) require an Accept and Expend Resolution from both the Health Commission and the Board of Supervisors.

2. The Employee Development Fund is maintained as a project within the City’s financial accounting systems.
   a. Sub Fund – 5LAGTDF
   b. Index Code – HLHAGTEDF
   c. Project Code – PHLEDF

3. The EDFM Committee shall consist of representatives from the following Divisions/Departments: Administration, Finance, Human Resources, Medicine, Nursing, Operations and Quality Management.

4. Requests for funding of employee development activities shall be submitted to the Chair of the EDFM Committee.

5. Proposals and recommendations for use of the fund shall be reviewed by the EDFM Committee and submitted to the Executive Committee by the Chair of the EDFM Committee.

6. Expenditures of the fund are subject to the hospital’s budgetary processes and purchasing requirements.

7. The Chief Financial Officer, on behalf of the EDFM Committee, shall provide quarterly financial reports to the Executive Committee.

8. Oversight of the fund is the responsibility of the Executive Committee.

9. Staff training sponsored by the fund requires a course certificate or proof of completion of the training classes to be eligible for the reimbursement of the training costs.

10. Staff from the Department of Education and Training and Nursing Education shall be responsible for coordinating employee in-service presentations and/or the dissemination of training materials (described in Policy statement # 7) for the benefit of the larger Laguna Honda employee community.

ATTACHMENT:
None
REFERENCE:
LHHPP 45-03 Donations
LHHPP 65-01 Procedures for Grant Application, Acceptance and Expenditure
Financial Administration of Grants and Gifts:
City and County of San Francisco Budget and Appropriation Ordinance, Administrative
Provisions Section 11.23, Fiscal Years 2012-2013 and 2013-2014

Original adoption: 15/11/09
ANNUAL PHYSICAL INVENTORY COUNT

POLICY:
Materials Management and Central Supply will conduct an annual physical inventory count at the end of each fiscal year.

PURPOSE:
1. To provide an annual accounting of on-hand quantities in inventory.

2. To provide a financial value of inventory for fiscal year closure.

PROCEDURE:

1. Timeline
   The annual physical inventory count will be conducted on the last Saturday of June or on a day mutually agreed upon by the Laguna Honda Accounting Department (internal auditor) and Materials Management/Central Supply. All staff of Materials Management and Central Supply are expected to participate.

2. Definitions of Roles:
   a. Leader – the person in charge of facilitating the physical inventory count, answers incoming phone calls, and fields all questions from auditors or staff, and handles the count sheets.

   b. Data entry – the person will be tasked with entering the counts from the submitted count sheets to the inventory management software.

   c. Counters – staff physically counting items and logging onto the count sheets.

3. The leader
   a. Ensure that “Issue Processing” is turned off on the inventory management software.
   b. Check to make sure delivery documents have been received and stock put away.
   c. Ensure that any remaining pick tickets/stock issues are picked and set aside for delivery.
   d. Run stock status reports for Materials Management and Central Supply and save the reports in Materials Management’s L drive.
   e. Print physical inventory count sheets.
   f. Assign count sheets to individual counters.
g. Facilitate pre-inventory instructional meeting with all staff.

h. Field all requests from departments for supplies during the inventory count period and maintain a logsheet of the requests. If the request is urgent, the leader will:
   i. Physically pick the product from inventory.
   ii. Place a selected-color post-it (not yellow) on bin label with quantity taken unless there is an existing yellow post-it already on it. In that case, the leader will write the quantity taken on the yellow-post it with a minus sign.
   iii. Leader will document the item number and quantity taken on the logsheet.

4. The Counters
   a. Will receive a clipboard, yellow post-it notes, and pen
   b. Will be provided only one count sheet at any given time.
   c. Physically count each item per bin location and will annotate count sheets with count in the appropriate space. The count will be in the appropriate unit of measure. Each space on the count sheet should have a quantity written even if that number is zero.
   d. Address all questions, including unit of measure and item location, to the Leader for resolution.
   e. If the counter sees a colored post-it with annotated quantity taken, the counter will include that quantity with the count in the appropriate count sheet space.
   f. After counting an item, counter will place yellow post-it note on the bin label indicating the item has been counted.
   g. After completing the count for the sheet provided, the counter will sign/print name in appropriate space. The count sheet is placed in the Data Entry inbox.

5. Data Entry
   a. Will provide a data entry inbox and completed box.
   b. Will take count sheets from inbox and verify count sheet matches page in system by verifying the first and last item number and bin location on page.
   c. Enter counts in appropriate spaces in the inventory management software.
   d. After counts are entered, draw a diagonal line across sheet and sign at the bottom of diagonal line indicating sheet has been entered.
   e. Place sheet in completed box.
   f. Save data after each sheet is entered.
   g. Maintain completed sheets in numerical order.
   h. After all count sheets have been entered, data entry person will electronically submit counts for review.

6. After all counts have been entered in inventory management software:
   a. Leader will review inventory discrepancies between system on-hand inventory versus physical inventory count.
   b. Leader will create a recount sheet for discrepancies based on management's pre-determined dollar threshold.
c. Leader will assign recount sheets to teams of 2-3 counters.
d. Teams of counters will count items and document count in appropriate spaces on the count sheet. If the yellow post-it note has a quantity taken on it, the counter will add that number to the physical count.
e. After completing the count for the assigned count sheet, all members of the count team must sign/print their name on the count sheet and place in the data entry inbox.
f. Data entry person will enter the recount sheets into the inventory management software; they will draw a diagonal line across sheet and sign at the bottom of diagonal line indicating sheet has been entered.
g. After all recount sheets have been entered, the data entry person will electronically submit counts for review.
h. The leader will review inventory discrepancies between system on-hand inventory versus physical inventory count.
i. Leader will create a recount sheet for discrepancies based on management's pre-determined dollar threshold, higher dollar threshold than for the first recount.
j. Leader will physically count the items on the recount sheet(s), annotate count in appropriate spaces on the count sheet, and hand to data entry person to enter.
k. Data entry person will enter the recount sheets into the inventory management software; they will draw a diagonal line across sheet and sign at the bottom of diagonal line indicating sheet has been entered.
l. Once all sheets have been counted, the data entry person will electronically submit counts for review.
m. Leader will submit counts which will update on-hand quantities to the physical inventory counts.
n. Leader will run stock status reports for Materials Management and Central Supply and save to Materials Management’s L drive and print hard copy.

7. On July 1st of the new fiscal year, the 1944 Materials Manager, or designee, will run an inventory transaction report for all stock issues and purchases between end of physical inventory and June 30th, 11:59 PM.

8. The reconciled dollar amount from the inventory transaction report will be added to the post physical inventory stock status report. This dollar amount is reported to Laguna Honda Hospital Accounting Department on July 1st.

ATTACHMENT:
None

REFERENCE:
None

Original adoption: 7/31/15
CENTRAL SUPPLY INVENTORY CYCLE COUNT

POLICY:
Central Supply to maintain accountable and accurate on-hand inventory.

PURPOSE:
To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

1. ABC Analysis Report
   a. The ABC report (A=20% / B=20% / C=60%) based on usage will be used to determine the frequency of items are cycle counted per month.
   b. A list items are counted weekly, B list items are counted two times a month and C list items are counted monthly.

2. ABC Analysis Report Review
   a. Management will review the ABC Analysis Report periodically to review if the items are properly categorized.
   b. The 1944 Materials Coordinator will approve all changes to inventory cycle count segments. The 1944 Materials Coordinator may delegate this responsibility to the 1942 Assistant Materials Coordinator or 2392 Senior Central Processing and Distribution Technician.

3. Cycle Counts
   a. Staff will conduct cycle counts only and cannot adjust on-hand inventory unless approved by the 1942 Assistant Materials Manager.
   b. The Supervisor or Lead will review and investigate all inventory cycle count discrepancies prior to on hand adjustments.

4. Cycle Count Tracking and Record Retention
   a. A manual cycle count tracking log book will be maintained to record cycle count dates, staff counters, and which individual cycle counts was performed.
   b. All cycle counts will be stored for 1 fiscal year plus current fiscal year.

ATTACHMENT:
None
REFERENCE:
None

Original adoption: 7/31/15
INVENTORY DISCREPANCY REPORTING FOR MATERIALS MANAGEMENT AND CENTRAL SUPPLIES

POLICY:
A formal inventory discrepancy reporting and adjustment process shall be followed by materials management and central supply staff prior to a manual inventory adjustment.

PURPOSE:
Provide management oversight on manual inventory adjustments and to guide staff on the correct inventory discrepancy reporting procedure.

PROCEDURE:

1. When Materials Management or Central Supply staff becomes aware of an inventory discrepancy, the supervisor (or lead tech if no supervisor) is notified.

2. The supervisor will utilize Pathways Materials Management (PMM) reports to run a Balancing Inventory Transaction Detail report for the item.

3. Using the report, the supervisor will review pick tickets, materials and equipment logsheet, packing slips, cycle count sheets, and online delivery documents to identify and verify the actual on-hand quantity.

4. If there is an adjustment to be made, the supervisor will complete an Inventory Adjustment Form (Attachment 4.2)

5. The Inventory Adjustment Form will be submitted to the 1942 Assistant Materials Manager or 1944 Materials Manager for approval.

6. Once signature approval is obtained by the 1942 Assistant Materials Manager or the 1944 Materials Manager, the supervisor will adjust the on-hand inventory.

7. The Inventory Adjustment Form will be stored in the filing cabinet and maintained for 3 years.

ATTACHMENT:
4.2 Inventory Adjustment Form

REFERENCE:
None

Original adoption: 7/31/15
REPORTING AND DISPOSING OF OBSOLETE AND EXPIRED PRODUCTS

POLICY:
Materials Management and Central Supply staff will report and dispose of obsolete and expired products in a standardized format.

PURPOSE:
To provide definitions of obsolete and expired products and to provide a guideline for Materials Management and Central Supply staff to follow.

PROCEDURE:

1. Definitions:
   a. Obsolete: defined as no longer used by Clinical authority
   b. Expired: defined as 3 months prior to the manufacturer’s stated “End Use Date” or “expiration date” unless product is in short supply.

2. If Materials Management or Central Supply staff identify items in Central Supply, Materials Management, or Nursing Supply Carts as expired, they will remove the item and report the finding to their supervisor.

3. The supervisor will determine the best course of action, submit and obtain written approval on form 4.5: obsolete and expired items from the 1942 Assistant Materials Manager or 1944 Materials Manager for the appropriate disposition.

4. If there is an adjustment to be made to inventory, the supervisor will also complete an Inventory Adjustment Form (Attachment 4.2)

5. Obsolete or Expired items will be stored in a separate bulk location based on the disposition.

ATTACHMENT:
4.2 Inventory Adjustment Form
4.5 Obsolete and Expired Items Form

REFERENCE:
None
Original adoption: 7/31/15
# INVENTORY ADJUSTMENT FORM

**Directions:** Fill out one form for every item number that needs adjustment in the Pathways Materials Management System and get signature approval from 1942 Assistant Materials Manager or 1944 Materials Manager.

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Submit document with any applicable documentation.

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# Obsolete and Expired Items

Directions: Fill out one form for every supply or equipment that is obsolete or expired and get signature approval from 1942 Assistant Materials Manager or 1944 Materials Manager before making any adjustments.

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<td>PMM Item no:</td>
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<td>(if no PMM #, describe item or equipment)</td>
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<tr>
<td>Quantity on hand:</td>
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<td>Description of why supply or equipment is obsolete or expired</td>
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<td>Plan of Resolution:</td>
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<td>Submit document with any applicable documentation.</td>
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**Authorized Signature:**
1942 Assistant Materials Manager or 1944 Materials Manager

| Printed Name: | |
| Date Processed: | Processed by: |
CENTRAL SUPPLY STOREROOM SECURITY AND INVENTORY CONTROL

POLICY:

1. Non-Central Supply employees accessing Central Supply (CSR) storeroom will document items taken from CSR on Materials and Equipment Logsheet (attachment 4.3)

2. CSR staff will review logsheet and stock issue items to appropriate department.

3. Electronic identification badge access requires approval from Director of Materials Management; all non-CSR staff will need to sign the CSR Inventory Security Form (attachment 4.4) before access will be allowed.

4. Materials Management will track the issuance of grand master keys to DPH personnel; all grand master key recipients will sign CSR Inventory Security Agreement (attachment 4.4)

PURPOSE:

1. To reduce the risk of unauthorized loss of supplies.

2. To provide non-CSR staff access to urgently required medical supplies and equipment during the hours that CSR is closed.

3. To provide non-CSR staff a formal process to document items taken from CSR.

4. To provide Materials Management with the ability to monitor off-hour access via master key access or electronic identification badge access.

5. To ensure all staff with CSR access understand the Materials and Equipment Logsheet and how to complete it accurately.

PROCEDURE:

1. When Non-CSR staff require medical supplies or equipment and CSR staff are not available to assist, that employee will:

   a. Use electronic identification badge or master key to gain access to CSR storeroom.
b. Pick up clipboard with Materials and Equipment logsheet located on Will Call shelf located immediately on the left wall upon entering CSR.

c. Locate needed materials and/or equipment
d. Complete logsheet
e. Replace clipboard with logsheet back to original location.
f. Ensure CSR doors are properly closed and locked.

2. CSR staff will check logsheet daily; if items were taken, CSR staff will charge out items to appropriate department and notify materials management whenever this occurs.

3. The Materials and Equipment logsheets will be filed in CSR filing cabinet and retained for 2 years.

ATTACHMENT:
4.3 Materials and Equipment Logsheet
4.4 CSR Inventory Security Agreement

REFERENCE:
None

Original adoption: 7/31/15
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Description</th>
<th>Sample Bin Location</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>1</td>
<td>E. G. Kangaroo Feeding Pump</td>
<td>North 4, Each</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>E. G. LV Solution D5W 25ml Minidose</td>
<td>North 4, Packs (each, box, pack, roll)</td>
<td>2</td>
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</tbody>
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Sample Bin Location: North 4, Each

- Date: 
- Time: 
- Dept: 
- Name: 

Directions: Fill out one form per occurrence for any supplies and equipment removed from Central Supply. See sample bin label for how to.

Materials & Equipment Logsheet

Developed July 2015
CSR Inventory Security Agreement

I, ______________________________________, hereby acknowledge that I will be receiving electronic badge access to Central Supply (CSR) storeroom or a master key that accesses Central Supply. I have been advised, and I fully understand, that these are to be used solely for those functions I have been authorized to perform as part of my department’s work responsibility, and that the access authorization is for my exclusive use only. I hereby accept full responsibility for any and all activity that I conduct within CSR storeroom.

Furthermore, in accordance with this policy, and all previous policies regarding security, I agree not to transfer, loan, or share, my electronic identification badge to any other person or persons, or to otherwise allow access by anyone else using my badge or key in any other manner or under any other circumstances. If I ever have reason to believe that my badge or key has been compromised, I will report such information to the office of DPH Materials Management at Laguna Honda Hospital, 415-759-2326.

In addition, I understand that any violation of the terms of this agreement by me may be considered a misuse of my badge and/or key, and that any event of misuse may result in cancellation of my access to the system, and any other disciplinary action deemed appropriate by my department head.

I also agree that I have received and reviewed the Central Supply Storeroom Inventory Security Policy and Procedure and understand and agree to my part in the process, including, but not limited to, writing down all item #’s, descriptions, and quantities of items taken and ensuring that the door is secure when I exit from CSR.

User Print Name: __________________________________________

User Signature: __________________________________________

Department: ____________________________________________

Date: _________________________________________________

Laguna Honda Hospital & Rehabilitation Center
Central Supply Policies & Procedures
MATERIALS MANAGEMENT AND CENTRAL SUPPLY RECORD RETENTION FOR FILES

POLICY:
Materials Management and Central Supply will retain records for tracking and auditing purposes.

PURPOSE:
To provide guidelines to staff for storage and retention of purchasing, inventory management, and receiving records.

PROCEDURE:
Retain records in Materials Management warehouse as follows:

1. Annual Physical Inventory – 5 years
2. Cycle Counts – 1 fiscal year plus current fiscal year
3. Inventory Discrepancy Form – 3 years
4. Materials Management Delivery logbook – 3 years
5. Pick tickets – 3 months
6. Purchase Orders – 7 years
7. Packing Slips
   a. Just-in-time packing slips – 3 months
   b. Bulk PMM packing slips – 7 years
   c. FAMIS PO’s packing slips – 7 years
8. Materials and Equipment Logsheet – 1 year

ATTACHMENT:
None

REFERENCE:
None

Original adoption: 7/31/15
# INVENTORY ADJUSTMENT FORM

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1.80 Proper mopping of the floor

Established and Revised: New 5/15
Reviewed: 8/15

Policy: To clean and sanitize the floor on a daily basis.

Purpose: For sanitation purposes.

Procedure:

1. Gather the equipment that will be needed to sweep and mop the floor;
   - Wet Floor signs
   - Mop bucket
   - Mop handle with clean mop head
   - Broom and dustpan
   - Wash and Walk chemical dispenses out the of the Oasis Dispenser
   - PPE = Personal Protection Equipment such as gloves and apron.
   
   Other equipment that may be needed:
   - Clean rags
   - Stiff brush
   - Squeegee

2. Cone off the area or section that will be mopped with wet floor signs to alert others that the floor may be slippery and wet during/after the washing of the floor.

3. Wipe up any spills on the floor with a rag.

4. Use a broom and dust pan to sweep the floor area the will be mopped. Dispose any dust, dirt or debris into the garbage bin.

5. Fill up a mop bucket using the Oasis dispenser with Wash and Walk solution.

6. Apply the Wash and Walk solution on the floor with a mop.

7. Leave the floor until the solution to penetrate soil.
   If needed, use a stiff brush on the floor to help loosen soil.

8. Mop up or squeegee into the floor drain.

9. Do NOT rinse. Walk away and allow to air dry.

10. Remove wet floor signs once the floors has completely dried.

11. Clean mop bucket.

12. Put away cleaning supplies into the designated storage location.

13. Place soiled mop head into the receptacle.

If a staff member feels that the mop head is too worn-out or heavily soiled with grease to be reused, he needs to inform a supervisor. The supervisor or chef will evaluate the condition of the mop head prior to disposal.
1.85 **Galley Sanitation – using Galleys to sanitize resident meal trays**

Established and Revised: 5/15
Reviewed: 8/15

**POLICY:** Neighborhood Galley dishwashers may be used to clean, wash and sanitize meal trays and dishware according to established procedures.

**PURPOSE:** To properly sanitize resident’s meals trays in the Galley for proper warewashing when necessary and maintain food service operations for resident meals.

**PROCEDURE:**
1. Nursing staff shall return soiled meal trays to the Galley for proper warewashing by the Food Service Worker.
2. Prior to the ware washing process, the Food Service Worker shall record the dishwasher machine temperatures to ensure that it is operating within standards (Temperatures: Wash: 150°F; Final Rinse: 180°F; Pressure: 20). The chemicals used in the Galley are the same chemical used in the Main Production Kitchen, which include:
   - Ecotemp Ultra Dry
   - Solid Power Plus
   - Liquid Assure
3. To expedite the process and maintain existing meal delivery schedule, a team of three food service workers will consolidate, clean and sanitize two Neighborhoods into one galley.
4. To insure proper infection control, the Food Service will sanitize the wheels of the delivery carts with Mikroklene prior to transport. All soiled trays will be secured inside an enclosed stainless steel transport cart.
5. In the designated neighborhood Galley, the team will wash and sanitize all meal trays and dishware, mugs and silverware through an approved, commercial grade dishwasher machine located inside the Neighborhood Galley. The job assignments will be divided among the team:
   - One food service worker will work on the soiled end of the dishmachine by scraping the soiled dishware and loading the dishmachine.
   - One food service worker will work on the clean end of the dishmachine by unloading and stacking the clean, sanitized and dried dishware.
   - One food service worker will clean and sanitize the delivery carts that will be used to transport clean and sanitized dishware.
6. The Food Service Worker will use the three-bucket cleaning procedure for the following:
   - The delivery carts
   - The work counters
   - The dishwasher machine
   *(Reference to Nutrition Services Policy & Procedures: 1.164 General Cleaning and Sanitizing Work Surfaces and Kitchen or Galley Equipment)*
7. All cleaned and sanitized ware shall be brought back to the Tray Service Area by the Food Service Worker before the next meal service.
8. A Porter will dispose of compost, recycle and garbage.
9. The Food Service Supervisor and Team Leaders are responsible for monitoring the Galleys for sanitation compliance.
HOSPITAL ORGANIZATIONAL CHART

POLICY:
Laguna Honda will maintain an organizational chart describing supervisory relationships from executive through departmental levels.

PURPOSE:
To describe the Hospital’s administrative organization.

PROCEDURE:
1. A copy of the Hospital's administrative organizational chart representing supervisory relationships from executive through departmental levels will be maintained in Administration.

2. The Hospital’s administrative organizational chart will be distributed hospital-wide posted online when changes are made.

ATTACHMENTS:
None

REFERENCE:
Laguna Honda Hospital Administrative Organizational Chart

Revised: 01/10/20, 09/10/27, 10/07/20, 11/05/13, 15/10/09 (Year/Month/Day)
Original adoption: 92/05/20
DISTRIBUTION AND PRODUCTION OF COLLATERAL MATERIALS

POLICY:

All newsletters, fliers, handbooks, brochures, research papers, speeches, web content, grant submissions, advertising, public relations materials, items of clothing, accessories and other collateral materials intended to represent Laguna Honda Hospital and Rehabilitation Center will be consistent with the brand identity and message of the Laguna Honda marketing campaign. All collateral materials that represent Laguna Honda Hospital and Rehabilitation Center and or reference hospital services and programs will be consistent with the style guide established for San Francisco Health Network. This includes but is not limited to newsletters, fliers, handbooks, brochures, research papers, speeches, presentation slides, grant submissions, advertisements, public and community relations materials, clothing items, and small accessories.

PURPOSE:

To ensure quality and consistency of all hospital materials, to ensure that all such materials reflect the unique design of a rebranded Laguna Honda Hospital and Rehabilitation Center, and to ensure that the hospital speaks with a consistent voice.

To provide quality control and to ensure all hospital materials reflect Laguna Honda and Rehabilitation Center as part of San Francisco Health Network.

PROCEDURE:

1. Originators will forward materials to the appropriate department head.

2. Department heads, in consultation with the Communications Office, will consult with the local Communications Office to make sure that collateral material is consistent with the Laguna Honda brand identity and message. San Francisco Health Network style guide. If changes are necessary, materials will be returned to originators for corrections to be completed.

REFERENCES:

None

Revised: 07/12/04, 09/10/27, 11/03/24, 15/10/09 (Year/Month/Day)

Original Adoption: 07/12/04
ADMINISTRATOR ON DUTY

POLICY:

During business hours, the Laguna Honda Executive Administrator/designee is the highest ranking administrator for the hospital. The Executive Administrator/designee is available to respond to emergency situations during business hours (M-F 8 am to 5 pm, except holidays and weekends). During non-business hours (M-F 5 pm-8 am, Weekends and Holidays 24/7), the Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) Administrator on Duty (AOD) is the highest ranking administrative authority for the hospital. An AOD is available twenty-four hours a day, seven days per week. The AOD on schedule is available to respond to emergency situations during non-business hours.

PURPOSE:

To provide clear lines of administrative communication and oversight twenty-four hours a day—during non-business hours.

PROCEDURE:

1. The Executive Administrator is responsible for identifying members of the Executive staff who are designated as AOD and listed on the AOD rotation.

2. The administrator on-duty (AOD) acts on behalf of the Executive Administrator to address immediate problems or incidents that occur during non-business hours. S/he is responsible for application of administrative actions guided by Laguna Honda policy and practice.

3. The AOD is on call during non-business hours (M-F 5 pm-8 am, Weekends and Holidays 24/7). or when the Executive Administrator is otherwise unavailable.

4. AOD responsibilities:
   a. Notify nursing office and telephone switchboard operator and operations nurse manager of any temporary changes in telephone numbers.
   b. Respond within 30 minutes when notified by Operations Nurse Manager or Nursing Office Staff.
   c. Respond onsite, if requested by the Operations Nurse Manager and assume administrative responsibility for emergency situations.
   d. Work with the Operations Nurse Manager, Nursing Office Staff, Executive Colleagues and/or Department Heads to address areas of concern(s).
e. If the AOD does not respond within 30 minutes from receiving a call, the operator Operations Nurse Manager shall first call the most appropriate Executive Staff member for the issue needing to be addressed. If the appropriate Executive Staff member is not available, the operator Operations Nurse Manager/Nursing Office Staff shall then call the next AOD scheduled on the list.

f. Informs DPH Central Office/Director’s Office when HICS is activated.

5. If the AOD has a scheduling conflict, the scheduled AOD may contact another AOD on the rotational cycle for coverage. The AOD who has the scheduling conflict is responsible for notifying the Executive Administrator’s office to make the scheduling changes.

6. The Administration office Services is responsible for:

   a. Maintaining the AOD schedule and posting the schedule on the intranet.
   
   b. Notifying the AOD two weeks before the assigned schedule, which begins at 8:00 a.m. Thursday morning.
   
   c. Maintaining the list of Executive members Staff who are on the AOD rotational cycle and their current contact information.

   d. Making changes of contact information and scheduling, and notifying the Nursing Office and the operator in writing 24 hours prior to the effective date of the change when notified by the AOD of the changes.

7. When the following events occur, the AOD will be contacted by the Operations Nurse Manager and the AOD will then inform necessary Executive staff, including the Health Director:

   i. Sentinel events, i.e. suicide, assault or abduction, major accident or injury, unexpected or unusual death
   
   ii. epidemic/communicable disease
   
   iii. serious security breach
   
   iv. significant security issue(s)
   
   v. significant utility malfunction
   
   vi. significant communication issues (e.g. downtime)
   
   vii. fire, earthquake or other major disaster
viii. hazardous material spill

ix. media event

x. regulatory visit outside regular business hours

8. If HICS is activated, the AOD/designee will notify the DPH Central Office/Director’s Office at (415) 554-2526 during business hours and xxx-xxxx during non business hours via appropriate and available means, (e.g. cellular phone), during non-business hours.

9. The Executive Committee members Staff are responsible for:

   a. Serving as consultative resources to the AOD when necessary

   b. Contacting Administration staff Staff if there are changes to their contact information

ATTACHMENT:
None

REFERENCE:
AOD Schedule
LHHPP 60-12 Sentinel and Significant Events

Revised: 92/05/20, 00/07/13, 07/08/13, 07/12/04, 09/10/27, 11/05/13, 13/01/29, 15/10/09 (Year/Month/Day)
Original adoption: 88/01/22
POSTING NOTICES, HANGING ARTWORK, AND CARING FOR THE BUILDINGS

POLICY:

1. Placement of Notices and Art
   
a. Notices: It is the policy of Laguna Honda Hospital and Rehabilitation Center to provide public bulletin boards in order to display information that may be of interest to residents, visitors, volunteers and staff.

   The posting of notices in areas other than bulletin boards, wall-mounted plastic holders or display stanchions is prohibited. This applies to notices placed in all public areas including lobbies, hallways, elevators, parks and gardens, parking lots and resident neighborhoods with the exception of nurses’ stations.

   Authority to approve notices for posting rests with the Executive Administrator or designee, including department and or division heads.

   Unapproved notices are subject to removal by designated staff. Approved notices may be removed by designated staff after a reasonable time - or when notices are no longer applicable, whichever is earlier.

b. Artwork: Any artwork, whether in public areas or resident rooms, must be hung by Facilities Services staff members or designated individuals working under their supervision. Authority to approve artwork for all public areas rests with the Executive Administrator or designee. The hospital supports the right of residents to select artwork for their rooms.

2. Care for the Buildings. It is the policy of Laguna Honda Hospital and Rehabilitation Center to respect the status of its buildings as an environment for living. All Laguna Honda staff are charged with the following responsibilities:

a. Picking up after themselves,

b. Leaving rooms and meeting spaces the way they found them,

c. Fulfilling their job duties in a manner that causes the least possible stress to the buildings, including leaving walls and doors free of marks and other damage,

d. Adhering to the guidelines in this policy for posting notices and artwork,

e. Keeping hallways and public spaces free of storage,
f. Properly using service corridors so that resident living spaces are undisturbed by service traffic, 

g. Respecting the pace of resident life in the neighborhoods, households, Wellness Center, and public areas, so that necessary maintenance, housekeeping, public tours, and administrative duties are conducted with attention to resident needs and preferences, and 

h. Maintaining a quiet and courteous atmosphere, and 

i. Reporting all visible occurrences of damage to the buildings to Environmental Services or Facility Services.

PURPOSE:

The purposes of this policy are as follows:

1. to maintain a homelike and therapeutic environment,

2. to support the upkeep of the buildings,

3. to ensure the reasonable management of all notices posted in public areas on hospital grounds, and

4. to comply with fire and safety regulations.

DEFINITION:

"Notices" includes but is not limited to fliers, signs, announcements, and other advisories.

PROCEDURE:

1. Individuals wishing to post notices will request approval from the appropriate department and or division head.

2. Department and or division heads will direct that notices be placed on bulletin boards, in wall-mounted plastic holders or in display stanchions, and will recommend a reasonable time for removal.

3. Activity Therapy staff will maintain access to stanchions.

4. Communications staff will be available for design and messaging assistance.

5. For artwork, department and or division heads will direct that individuals requesting placement work under the supervision of Facilities Services staff.
UNION RELATED INFORMATION:

Union notices are subject to the terms stipulated in the collective bargaining agreement.

Revised: 07/12/04, 09/10/27, 11/03/24, 15/11/09 (Year/Month/Day)
Original adoption: 92/05/20
MEDIA RELATIONS POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (“Laguna Honda”) to protect every patient’s / resident’s (“resident”) right to privacy. Protected health information may be released only for approved purposes, with proper authorization from the resident, conservator or guardian when required, and in accordance with state and federal laws as discussed in Laguna Honda’s policies and procedures.

2. Laguna Honda staff are directed to refer media inquiries to the Communications Director or designee—Hospital Assistant Administrator. In the event that the Hospital Assistant Administrator is not available, Laguna Honda staff are directed to refer media inquiries to the Department of Public Health (DPH) Public Information Officer (PIO).

3. The Laguna Honda Hospital Assistant Administrator or designee has the primary responsibility for managing the media, including all inquiries, news releases initiated by Laguna Honda, public comments on behalf of the hospital, web postings, and news releases involving persons associated with Laguna Honda. The Hospital Assistant Administrator or designee is responsible for determining the news value of a story and may consult with DPH and Laguna Honda executive colleagues, as well as the form, method, time and sources of the dissemination of relevant information.

4. The Hospital Assistant Administrator will inform the Laguna Honda Executive Administrator, Administrator on Duty, and the appropriate—Associate Administrator—Hospital Executive Committee of any high-profile media issues.

5. Laguna Honda may deny the media / press access to any area of the campus including, but not limited to, the resident neighborhoods and households, patient/resident care areas, acute care units, and rehabilitation center. If media / press is granted access to Laguna Honda, the Hospital Assistant Administrator or designee must accompany the media / press at all times.

PURPOSE:

The purpose of this policy is to provide guidelines for:

1. Protecting residents’ rights to privacy with regard to media exposure

2. Media / press inquiries

3. Information that may be publicly released

4. Authorization and consent to interview, photograph or videotape
PROCEDURE:

1. Residents’ Rights.
   a. Information is to be released only with specific authorization from a resident, legally authorized surrogate decision-maker, guardian or conservator.
   b. Residents have the right to request cessation of interviewing, photographing, recording or videotaping / filming.
   c. Residents have the right to rescind consent for use up until a reasonable time before the photograph, recording or videotape / film is used.

2. Media / Press Inquiries and Release of Information
   a. Staff who know of a "story" are directed to work through Administration so the release of information can be coordinated and handled according to Laguna Honda policy. When appropriate, the Hospital Assistant Administrator will work with the Department of Public Health (DPH) - Public Information Officer in the management of media relations.
   b. All press / media inquiries are coordinated by the Hospital Assistant Administrator, (415) 759-3576 or designee.
   c. In the absence of the Hospital Assistant Administrator or an on-campus designee, media calls will be referred to the Public Information Officer at the Department of Public Health, at DPH (415) 554-2507.
   d. Off-hours (Mon. - Fri.: 5:30 pm through 8:30 am), weekends, and on holidays: All media calls through the switchboard or Nursing Office are directed to the Administrator on Duty (AOD). The AOD may provide basic information, and should consult with the information officer on call. An information officer from the hospital or the Department of Public Health will be on call 24 hours / day, seven days / week.

3. Authorization and Consent to Interview, Photograph or Videotape for Media Purposes
   a. Residents who have no decision-making authority and no surrogates may not be photographed or interviewed by the media.
   b. Permission to interview / photograph / videotape may be given if the resident has signed a written consent. The signed consent must be filed in the resident’s medical records and in the administration office.
   c. If representatives from the news media request to photograph, videotape or interview a resident, request information about a resident, or request access to
family members, the request must be submitted to Administration for approval prior to access. The Hospital Assistant Administrator will request consent from the resident, legally authorized surrogate decision-maker, guardian or conservator with assistance of the charge nurse and physician assigned to the neighborhood where the resident lives. Management of these types of requests is done during regular Administration business hours, 8:30 a.m. to 5:30 p.m. Monday through Friday. High profile residents or situations may require Administration staff, AOD, or nursing staff on all shifts to communicate status and updates to the next shift.

5. Department of Public Health (DPH)
   All inquiries regarding DPH administration, programs, or policies will be referred to the DPH Public Information Officer at (415) 554-2507.

ATTACHMENTS:
Appendix A: Information Officer Contact Info
Appendix B: Authorization for Non-Clinical Photograph or Recording
Appendix C: January 2011 Memo Re: Media Policy from Barbara A. Garcia, MPA, and Director of Health

REFERENCES:
LHHPP 01-06 Administrator on Duty
LHHPP 20-01 Admission to Laguna Honda and Relocation between Laguna Honda SNF Units
LHHPP 21-01 Medical Records Information: Confidentiality and Release
LHHPP Residents' Rights

Revised: 07/12/04, 09/10/27, 11/03/24, 14/11/25, 15/10/09
Adoption date: 88/01/22
## Appendix A

Information Officer Contact Information

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Office Number</th>
<th>Cell Phone No.</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHH Hospital Executive Administrator</td>
<td>Mivic Hirose</td>
<td>759-2363</td>
<td>Refer to AOD Schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Hospital Assistant Administrator</td>
<td>Vacant</td>
<td>N/A</td>
<td>Refer to AOD Schedule N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Chief Operations Officer</td>
<td>Vacant</td>
<td>N/A</td>
<td>Refer to AOD Schedule N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Acting Chief Operations Officer</td>
<td>Vacant</td>
<td>N/A</td>
<td>Refer to AOD Schedule N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Acting Chief Operations Officer</td>
<td>Vacant</td>
<td>N/A</td>
<td>Refer to AOD Schedule N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Assistant Hospital Administrator</td>
<td>Vacant</td>
<td>N/A</td>
<td>Refer to AOD Schedule N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>LHH Administration Services</td>
<td>Main Number</td>
<td>759-2363</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>DPH Public Information Officer</td>
<td>Rachael Kagan</td>
<td>554-2507</td>
<td>N/A</td>
<td><a href="mailto:Rachael.Kkagan@sfdph.org">Rachael.Kkagan@sfdph.org</a></td>
</tr>
<tr>
<td>LHH Administrator on Duty</td>
<td>Schedule rotates refer to Intranet or call the Nursing Office</td>
<td>682-1502</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Appendix B

Authorization for Non-Clinical Photograph or Recording

Laguna Honda Hospital and Rehabilitation Center

AUTHORIZATION FOR NON-CLINICAL PHOTOGRAPH OR RECORDING

Residents’ Rights

1. I may request that filming or recording stop at any time.
2. I may rescind this Authorization up until a reasonable time before the photograph is used by making an oral request of the person asking me to sign this form.
3. I may request a copy of the photograph whose use or disclosure I am authorizing.
4. I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
5. I have a right to receive a copy of this Authorization.
6. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure in some cases is not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Key policies for hospital staff to be aware of regarding the use of this form

1. All residents sign an admission agreement that states: “You agree that we may take photographs of you for identification and health care purposes. We will not take a photograph of you for any other purpose, unless you give us your prior written permission to do so.” The admissions agreement applies to admission photographs only. All other photos, images, or recorded interviews must be consented to by using this form.
2. Pursuant to Department of Public Health (DPH) policy, brochures or publications developed by DPH-funded programs are not to include identifiable clients in photos or personal stories that disclose their current or past mental health issues or substance use, or engagement in behavioral health services. This policy applies to current, previous, and deceased clients and to cases even where the client has requested or authorized DPH staff to present them in publications.
3. Pursuant to DPH policy, information may not be released to the media about identifiable DPH clients engaged in behavioral health services (including those served in outreach, mental health, substance abuse, HIV, or supportive housing programs). This policy applies to current, previous, and deceased clients and to cases even where the client has requested or authorized DPH staff to speak to the media.
4. Only the resident or decision maker may consent.
5. This consent applies only to the purpose specified. Additional purposes require another consent.
AUTHORIZATION FOR NON-CLINICAL PHOTOGRAPH OR RECORDING

The undersigned authorizes Laguna Honda Hospital and Rehabilitation Center to make recordings or photographs for the purpose(s) specified, and to permit the use or distribution of such recordings, images or photographs consistently with statutory and regulatory protections of personal health information.

The undersigned waives any right to compensation for uses authorized under this agreement and holds harmless Laguna Honda and any individual staff member of the Department of Public Health from claims for injury or compensation resulting from activities authorized by this agreement.

- Purpose. (Please indicate on this line what the photo or recording will be used for.)

- Request For: □photograph □videotape □interview □voice recording
  □drawing □other __________________________

- □ If the box to the left is checked, the hospital will receive compensation for the use or disclosure of my photograph or record.

- Person Requesting Consent:

- Resident name (print):

- Date consented: __________________________

- Signature of resident or decision maker: __________________________

- If signed by someone other than the resident, print name and indicate legal relationship to resident:

  Printed Name __________________________

  Relationship __________________________

- Witness Name:

- Witness Signature: __________________________

(Date and Time) __________________________
AUTHORIZATION FOR NON-CLINICAL PHOTOGRAPH OR RECORDING

The undersigned authorizes Laguna Honda Hospital and Rehabilitation Center to make recordings or photographs for the purpose(s) specified, and to permit the use or distribution of such recordings, images or photographs consistently with statutory and regulatory protections of personal health information.

The undersigned waives any right to compensation for uses authorized under this agreement and holds harmless Laguna Honda and any individual staff member of the Department of Public Health from claims for injury or compensation resulting from activities authorized by this agreement.

- Purpose. (Please indicate on this line what the photo or recording will be used for.)
- Request For: □ photograph □ videotape □ interview □ voice recording
  □ drawing □ other ________________________________
- □ If the box to the left is checked, the hospital will receive compensation for the use or disclosure of my photograph or record.
- Person Requesting Consent:
- Resident name (print): __________________________
- Date consented: ________________________________
- Signature of resident or decision maker: ____________
- If signed by someone other than the resident, print name and indicate legal relationship to resident:
- Printed Name: ________________________________
- Relationship: ________________________________
- Witness Name: ________________________________
- Witness Signature: ________________________________
  (Date and Time)
Appendix C

January 2011 Memo Re: Media Policy from Barbara A. Garcia, MPA, and Director of Health

San Francisco Department of Public Health

Policy & Procedure Detail*

| Category: External Affairs |
| Effective Date: January 1, 2011 | Last Revision Date: |
| DPH Unit of Origin: Office of the Director |
| Policy Owner: Eileen Shields | Phone: 554-2507 | Email: eileen.shields@sfdph.org |
| Distribution: DPH-wide | Other: |

*All sections in table required.

1. Purpose of Policy
   This policy and procedure (P&P) is necessary in order to ensure a consistent, unified message to the media regarding the policies and activities of the San Francisco Department of Public Health (DPH). It also allows DPH to track the issues that are making news and to allow the Public Information Office to remain informed about which public health topics are of interest to the media. In many cases, reporters are at the front line of significant public health breaking news stories.

2. Policy
   DPH’s Media Policy requires that all staff inform the Public Information Office before:
   - Making a statement or granting an interview with a reporter or member of the media; and/or
   - Permitting photography or videography in any workplace location.

3. Procedures
   a. Responding to a media request:
      If contacted by a reporter, employees should refer the reporter to the Public Information Officer (PIO) assigned to the appropriate program or facility. Alternatively, the employee can call or e-mail the Public Information Officer directly for advice. There are three individuals that comprise DPH’s Public Information Office:
      - Eileen Shields: DPH Administration & Community Programs, 554-2507, eileen.shields@sfdph.org
      - Rachel Kagen: San Francisco General Hospital, 206-3170, rachel.kagen@sfdph.org
      - Marc Slavin: Laguna Honda Hospital, 759-2350, marc.slavin@sfdph.org

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans. We shall: Assess and research the health of the community • Develop and enforce health policy • Prevent disease and injury • Educate the public and train health care providers • Provide quality, comprehensive, culturally proficient health services • Ensure equal access to all
Title of Policy: DPH Media Policy (EXF2)  

Effective Date: 1/1/11

An employee must contact their PIO regardless of the situation. It does not matter where the employee is or what is happening, if it is related to the individual’s work at DPH, the PIO is the first point of contact before arranging an interview. This is true regardless of how insistent the reporter appears or if their deadline is quickly approaching. There is no exception to this policy during an emergency. In fact, it is even more important during an emergency to involve the Public Information Office.

b. Interacting with reporters during non-work time:
DPH employees, while acting as individuals on their non-work time, are permitted to speak to a reporter without checking with anyone and/or obtaining permission through DPH. However, the employee is required to make it clear to the reporter that he/she is not speaking in any official capacity as a DPH employee. The PIOs are available to provide any guidance that you may need on this matter.
RESIDENT RIGHTS

POLICY:

1. Patient/Resident rights are honored without regard to cultural, economic, educational, religious background, sexual orientation, gender identity, disability or the source of payment for his/her care.

2. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) staff collaborates with the San Francisco Ombudsmen Office in their role as residents rights advocate.

3. All residents of Laguna Honda are informed of their rights and responsibilities, and are further required to acknowledge receipt of having received a copy of those rights and responsibilities, as well as an explanation if requested.

4. A list of patients'/residents' rights is posted or available in appropriate places within the hospital.

PURPOSE:

To assure that each patient/resident is knowledgeable about his/her rights and the methods and circumstances by which those rights can be withheld. These rights comply with Title 22, California Code of Regulations Section 70707 and 72527.

PROCEDURE:

1. Prior to, or upon admission to Laguna Honda Hospital and Rehabilitation Center, the (a) Admitting Clerk or (b) a member of the Eligibility staff will give to the resident, or his representative or responsible relative, a copy of the resident's rights form and will have a receipt acknowledged by the signature of the receiving party.

2. The receipt (acknowledgement) is placed in the resident’s medical chart.

3. Discrepancies regarding these procedures should be brought to the attention of the Director, Admissions and Eligibility Department.

ATTACHMENT:

Appendix A: List of Residents’ / Patients’ Rights

REFERENCE:

Resident Rights Web address:

Revised: 09/06/2002, 9/30/2008, 10/04/27, 15/10/09 (Year/Month/Day)
Original adoption: 01/22/1988
Appendix A:

LIST OF RESIDENTS’ / PATIENTS’ RIGHTS

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

17. Know which hospital rules and policies apply to your conduct while a patient.

18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
a. No visitors are allowed.

b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

c. You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

20. Examine and receive an explanation of the hospital’s bill regardless of the source of payment.

21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care.

22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or calling:

   Mivic Hirose, RN, MS, CNS
   Executive Administrator
   Administration Department
   Laguna Honda Hospital
   375 Laguna Honda Boulevard
   San Francisco, CA 94116
   (415) 759-2363

   The grievance committee will review each grievance and provide you with a written response within 5 days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).
23. File a complaint with the state Department of Public Health regardless of whether you use the hospital’s grievance process. The state Department of Public Health’s phone number and address is:

Licensing and Certification—Daly City District Office
350 90th Street, 2nd Floor
Daly City, CA 94015
Phone: (650) 301-9971
Fax: (650) 301-9970

Department of Public Health Licensing & Certification
San Francisco District Office
150 North Hill Drive Suite 22
Brisbane, CA 94005
Phone: (415) 330 6353
Fax: (415) 330 6350
THE FARM AND THERAPEUTIC GARDENS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) maintains facilities that house animal assisted therapy and horticulture programs. These facilities and related programs are referred to as the Farm and Therapeutic Gardens.

PURPOSE:

1. To provide the residents of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) with programs beyond traditional activities which contribute to resident quality of life and sense of normalcy.

2. To honor the traditions of Laguna Honda.

3. To benefit the Laguna Honda community as well as the greater San Francisco community.

PROCEDURE:

1. The facilities including enclosures housing animals, a greenhouse, gardening plots, and a fruit tree orchard is maintained as partnership between the Activity Therapy and Facility Services Departments.

2. The Activity Therapy Department staffs the Farm. The department deploys other staff resources, including volunteers, towards the operation of the Farm. Staffing is managed to maintain care for the animals and plants every day.

3. The Activity Therapy Department utilizes the facilities, and associated plants and animals in the implementation of animal assisted therapy and horticulture programming which include program provided at the Farm and inside the hospital. Farm staff coordinates, maintains, and publishes a listing of programs and activities designed for resident involvement.

4. A regular schedule of feeding and care for the animals, including the cleaning of the facilities is established and implemented by the Farm staff.

5. Scheduled maintenance for the facilities and the plants is established and implemented by the Farm staff. Farm staff consults the hospital’s gardeners on the maintenance of the facilities and plants.

6. The acquisition of animals to be housed at the Farm and used within the animal assisted therapy is limited to animals that can be appropriately maintained in such a way as to pose no harm to humans and/or animals. Farm staff continuously assess
the temperament and health of the animals to ensure they are appropriate for the program. Animals deemed to be inappropriate for the programs are removed and relocated to other programs and/or facilities where they will receive humane treatment.

7. The services of a veterinarian are employed to ensure the ongoing health of the animals involved in the animal assisted therapy program.

8. The gardeners utilize a section of the greenhouse for the propagation and rehabilitation of plants to be used on hospital grounds.

9. The yield of plants produced through horticulture programming is intended to be used within the hospital including beautification of hospital facilities. **The production of fruits and vegetables is not intended for intended for resident consumption** is handled within established food safety guidelines. Fruits and vegetables can only be grown inside the greenhouse. Eggs are disposed of using the compost bin. The production of fruits and vegetables is not intended for resident consumption.

10. The greenhouse, gardening plots, and the orchard are maintained using natural approaches to pest management. No pesticides or herbicides are used.

11. The Facility Services Department maintains a regular schedule of maintenance to the Farm facilities.

12. The collaboration with community groups in the ongoing operation of the Farm and Therapeutic Gardens is welcomed and administered by the Activity Therapy Department.

12. **Activity Therapy Staff are provided education on safe animal handling and garden usage will occur annually for program purposes during orientation and annually thereafter.**

**ATTACHMENT:**
None

**REFERENCE:**
None

Revised: 15/11/09
Original adoption: 10/11/10
POOL SERVICING AND AQUATIC AREA GENERAL MAINTENANCE

POLICY:

Facilities Services, Environmental Services and Wellness Program staff will regularly maintain, clean, and repair the aquatic area and pools.

PURPOSE:

1. Facility Services is responsible for water quality and maintaining equipment by certified staff.

2. Environmental Services will provide a clean and safe environment both in the pool area and the locker rooms.

CHARACTERISTIC:

1. Pools

   a. **A: Pool #1: Large Pool (recreational)**
      
      i. Surface Area: 834 Square Feet (maximum capacity of 40 people)
      ii. Depth: 3 feet to 5 feet
      iii. Water Capacity: 24,150 gallons
      iv. Water turnover rate: 2 hours @ 202 GPM
      v. Filters: Two High-Rate Pentair Sand Media
      vi. Heater: Lockinvar 300K BTU Gas Fired (kept at a lower temperature than the smaller pool)

   b. **B: Pool #2: Small Pool (therapy)**
      
      i. Surface Area: 306 Square Feet (maximum capacity of 8 people)
      ii. Depth: 3 feet to 5 feet
      iii. Water Capacity: 8,300 gallons
      iv. Water turnover rate: 2 hours @ 69 GPM
      v. Filters: One High-Rate Pentair Sand Media
      vi. Heater: Lockinvar 300K BTU Gas Fired (kept at a higher temperature than the larger pool)

2. Locker Rooms

   a. Description:
      Men: 22 lockers (incl 6 tall)
      Women: 22 lockers (incl 6 tall)
      Family: 4 locker (incl 2 tall)

3. Deck
a. Description:
   BASF Non-slip surface of approximately 1725 square feet

b. Drains
   20 total perimeter drain pots that channel deck water to waste

4. Lifts

   a. Angel Lift- description:
      Mfr: Waverly Glen Systems, Ltd
      Toronto, Ontario Canada
      1-800-265-0677
      Maximum lifting weight: 625 pounds, one person capacity

   b. Chair Lift- description:
      Mfr: Spectrum Products
      7100 Spectrum Lane
      Missoula, Montana
      406-542-9781
      Maximum lifting weight: 400 pounds, one person capacity

5. The pool equipment, circulating pumps, filter and heater are operational 24 hours.
   All equipment is located in room PG242, the pool mechanical room. Manuals are
   located in the pool area and in the Facility Services Department.

DEFINITIONS:

1. “Facilities staff” is certified pool maintenance engineers unless otherwise stated.

2. “EVS” are Environmental Services staff.

3. “Wellness Program Staff” are staff from the Rehabilitation, Restorative Nursing, and
   Activity Therapy Departments responsible for participant programs.

4. “PMS” is preventative maintenance schedule for equipment completed by Facilities
   staff.

5. “Inspections” include, water temperature, chemistry and clarity, air temperature,
   humidity and circulation and are completed by Facilities staff.

6. “Walk through” is a security, safety and supply check completed by Program Staff.

7. "F" is Fahrenheit

8. "RH" is relative humidity.

PROCEDURE:
1. Facility Services

   a. Electrical Power:

      i. Electrical power is supplied from switchboard 1N1L1, breaker PNL SP, located in main electrical room of Pavilion Building Level L1.

   b. Daily Water Inspection

      i. Frequency: Inspections are conducted each morning, and a walk through inspection of the pump room in the afternoon and evening.

      ii. A check list which includes but is not limited to, water chemistry (pH 7.2-7.8), temperature (large pool 85-90 degrees, small pool 88-92 degrees) and clarity (must be able to see the main drain cover plate), see attachment A, (Aquatic Center Daily Inspection Readings form) is completed during each inspection.

      iii. The inspection check list becomes part of the maintenance logs maintained in a log book on deck.

      iv. Atypical situations:

         - If the results from the inspection are problematic, they must be communicated to the Wellness Program Staff and the Director of Facility Services.

         - If an alarm is sounded facilities staff will determine the cause, implement interventions and notify program staff.

         - If foreign matter is in the pool, determine how long the pool will need to be closed (at least 2 hours).

   c. Daily Air Inspection

      i. Frequency- Inspections are conducted each morning.

      ii. A check list which includes but is not limited to air temperature and humidity level, see attachment A, is completed during each inspection. The temperature of the room should be +/- 5 degrees F, above the large pool water temperature. The humidity level should not exceed 50% RH.

      iii. Follow up and Reporting
• If the results from the inspection are problematic, they must be communicated to the Wellness Program Staff and the Director of Facility Services as needed.

• The inspection check list becomes part of the maintenance logs maintained in a log book on deck.

d. Filtration:

   i. Sand Filters

   • Shall be monitored daily during initial inspection in the morning.

   • Cleaned by backwashing when the pressure differential between the influent and effluent pressure gauges equals 10-20 PSI, or when 70 GPM for pool#1 is attained, and 25 GPM for pool #2 is attained. (page 7 of manual)

   • Chemical Cleaning is completed as needed to remove oils, scale and rust from the sand bed.

   ii. Flow sensor and probe cell located at the chemical probe cabinet shall be checked for debris/blockages and cleaned daily during initial inspection in the morning.

   iii. Chlorine and acid pump (including associated components) shall be checked for wear, loose fittings and general operation daily during initial inspection in the morning.

   iv. Pump Strainers shall be checked and/or cleaned daily during initial inspection in the morning.

e. Removal of debris in the pools

   i. The squeegee may be used by any of the staff to remove large debris as needed. It is on deck. Staff should push debris toward the bottom drain for the filter to remove from the water.

   ii. The robot cleaner will be used as needed by the CPT to clean the bottom and sides of the pool. It will be put into the pool at closing time and removed before opening the next day.

f. Deck Equipment

   i. Pool Covers:
• Each pool shall be covered when pool complex is closed for maintenance not in use.

• Pool cover operator station is located on wing wall outside of pool equipment room.

• Power is supplied from circuit breaker panel SP located in the pool equipment room.

• Whenever someone is using either of the pools, both covers must be off.

• Cables for the covers must be clearly marked to alert anyone in the area of their presence.

ii. Lifts

• Angel lift See ceiling lift policy.

• Chair lift Refer to Swim-Lift Pintalar-325 Installation and Operation Manual.

2. Environmental Services

a. Locker room cleaning see Environmental Services Policy & Procedures
   i. xi. Hospital Cleaning Steps
   ii. xii. Critical Areas Cleaning Procedure
   iii. xiii. Sub-Critical Areas

b. Deck cleaning
   i. See attachment B Degadur Floor Cleaning And Maintenance Guide
   ii. Linen services: LHHPP 90-06 Revised December 24, 1998

c. Foreign matter in the pool:
   i. Environmental Services will:
      • Respond to call for assistance from program services staff.
      • Retrieve the biohazardous red container or bag from the EVS closet.
• Using the cleaning net in the supply room, remove any solid “foreign matter” from the pool.

• Place the “foreign matter” in the red container.


3. Wellness Program Staff

d. Daily responsibilities:

i. Do a walk through each morning to ensure that the supplies and equipment are available and functioning prior to opening the facility.

ii. Check gym equipment for problems

iii. Check locker rooms and stock body shampoo (order from Central Supply)

iv. Check linen

v. Check water reading log book for problems

vi. If problems are found, program staff will contact Facility Services, Infection Control and EVS as appropriate

vii. Cover the pools each evening, when not in use or closed.

e. Atypical circumstances:

i. Foreign matter in the pool:

• Evacuate the pool affected and nearby deck if necessary. (Each pool has separate filters)

• Contact Facility Services for pool operation.

• Contact EVS for assistance with the removal of foreign matter and disinfection.

• If EVS staff has not arrived and the foreign matter is solid, begin removal process.
• Inform residents and/or staff of pool closure and post closure signs.

• Secure the pool and deck from the gym and the locker rooms.

• If one of the pools is not affected, it may be used unless it is determined by Facility Services to be unsafe.

• Complete water contamination log. See attachment C: WATER CONTAMINATION RESPONSE LOG

ii. Chemical imbalance in the pool:

• Respond to the alarm and/or notification by evacuating the pool(s) affected by the imbalance.

• Secure that pool and post closure notices.

• Inform residents and resident care teams of the closure as needed.

iii. If the pool cover can not be fully deployed or retracted:

• Not leave the pool area until the cover is fully deployed or retracted or facility services staff relieve them.

• Call Facility Services staff for assistance.

• Secure the pool and deck by locking the doors to the pool area.

• The pool area can not reopen until the covers are able to be fully retracted.
ATTACHMENT:
Aquatic Center Daily Inspection Readings form
DEGADUR FLOOR CLEANING AND MAINTENANCE GUIDE
WATER CONTAMINATION RESPONSE LOG

REFERENCE:
Bermuda Gunite Skimmer Installation, Operation and Service Manual
California Code of Regulations, Title 22, Chapter 20, Public swimming pools
Center for Disease Control
Chemical balancing equipment manual
CLA-VAL Automatic Control Valves Installation, Operation and Maintenance
COLLECTION, HANDLING, STORAGE AND DISPOSAL OF BIOHAZARDOUS WASTE Issued: 4/97 Rev: 4/01
DEGADUR FLOOR CLEANING AND MAINTENANCE GUIDE
Eko Systems, Inc. Instructions for Eko Portable Vacuum
Environmental Products Division, Industrial-Commercial Filtration Assembly and Installation Instructions for EPD Modulating Valves
Heater manual
Lift manuals
MerMaid, FRP Basket Strainer Operation and Maintenance Instructions
Paco Pumps installation, Operating and Maintenance Instructions
Pentair pool products Triton Fiberglass Sand Filters Installation and User’s Guide
PH-MTS Carbon Dioxide Feed Systems manual
Pool-Pro Type SP Butterfly Valve Instructions
Pulsar 4 System Operator’s Manual, Chlorinator
Strantrol system 4 Controller operations Manual
Swim-Lift Pintalar-325 Installation and Operation Manual
Taylor Test Kits Instructions # 5510
T-Star Enterprises pool cover, Pool Blankets and automatic Reel Systems description, Operation, Specifications and Maintenance
Paco Pumps installation, Operating and Maintenance Instructions
Pool-Pro Type SP Butterfly Valve Instructions
Western Water Features, Inc Daily Cleaning Requirements List
WhisperFlo; Pump Owner’s Manual P/N 071109

Revised: 15/11/09
Original adoption: 03/24/2011
Attachment A

Laguna Honda Hospital and Rehabilitation Center

AQUATIC CENTER DAILY INSPECTION READINGS

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<th>Small Pool</th>
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<td>Reading</td>
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<td>PH level (7.2-7.8)</td>
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<td>CO2 Tank Level</td>
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<tr>
<td>Pump GPM (210 or 76)</td>
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<td>Air Temperature (~+5 above water temperature)</td>
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<tr>
<td>Water Temperature (85-90 LG)(88-92 SM)</td>
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<td>Humidity Level (up to 50%)</td>
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<td>Filter backwash completed (Required 147 or 53 GPM)</td>
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<td>yes / no</td>
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<td>Staff Initials</td>
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<tr>
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Laguna Honda Hospital-wide Policies and Procedures  Page 9 of 13
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<th>Reading</th>
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Attachment B

DEGADUR FLOOR CLEANING AND MAINTENANCE GUIDE

The following cleaning and maintenance guide will assist the user in maintaining the appearance of an installed DEGADUR flooring system.

By using these procedures and the correct tools recommended by BASF chemical companies-building systems, the user can extend the service life and retain the appearance of a DEGADUR MMA flooring system. A proper maintenance and cleaning schedule is recommended for all DEGADUR systems.

The following is a suggested list of tools for use on SRS DEGADUR floors:

1. Automatic scrubbers.
2. Power washers: up to 1,200 psi is sufficient.
3. Pads: white or red 3M or similar.
4. Brushes: nylon non-abrasive Malish 8129 series or similar medium flex bristle brush. Brushes should always be “broken in” according to manufacturer’s recommendations, prior to use on an SRS flooring system.
5. Brooms: medium/stiff bristle.
6. Mops: synthetic for non-skid floors; cotton or synthetic for use on smooth floors.
7. Wet vacuums.

Degreasing:
A non-solvent based degreaser designed for the type of grease involved (animal vs. petroleum based).

General Cleaning:
A cold water activated Butyl Cellosolve based cleaner such as Simple Green or similar is recommended.

Scuffs and Stains:
An abrasive cleanser can be used for scuff marks and tougher stains.

Smooth Floor

General Cleaning
1. Sweep floor to remove any loose debris.
2. Most areas require the use of a water based detergent. Dilute, mix and apply the detergent following manufacturer’s recommendations using a rayon or cotton mop. Allow the detergent to penetrate for five minutes.
3. Scrub floor with stiff bristle broom or rotary floor machine equipped with a scrub brush.
4. Remove contaminants with wet/dry vacuum or squeegee to drains.
5. Rinse areas thoroughly with cool, clean water and allow to dry. Use clean water for each rinse.
6. Vacuum and/or squeegee to drains.

Deep Cleaning
1. For stubborn spots a 3M Blue pad or medium – stiff brush can be used on a scrubber in conjunction with a detergent.
2. Scuff marks can be removed using an abrasive cleaner such as Comet, Ajax or similar cleaner.
3. These areas should then be rinsed with clean water.

Scratches/Damages
1. Cuts, gouges and rubber burns such as those caused by fork lifts or sliding heavy equipment across the floor can damage the SRS floor. If this occurs it should be addressed by contacting an approved SRS applicator to make necessary repairs to prevent moisture or contamination from entering the floor.
Non-Skid Profiled Floor

General Cleaning
1. Sweep floor to remove any loose debris.
2. Most areas require the use of a water based detergent. Dilute, mix and apply the detergent following manufacturer’s recommendations using a rayon mop. Allow the detergent to penetrate for five minutes.
3. Scrub floor with stiff bristle broom or rotary floor machine equipped with a scrub brush.
4. Remove contaminates with wet/dry vacuum or squeegee to drains.
5. Rinse areas with cool, clean water and allow to dry. Use clean water for each rinse.
6. Because of the texture of the non-skid surface the use of a pressure washer may facilitate the removal of contaminants from the surface. SRS floors can be steam cleaned but caution should be used to avoid prolonged exposure of steam directly on the floor. Constant movement should be maintained on the steam wand to avoid this problem.
7. A thorough rinsing using a hose may be required in order to adequately rinse a non-skid floor. If no floor drains exist, a wet vacuum can be used to pick up rinse water.

Deep Cleaning
1. For stubborn spots a stiff bristle brush can be used by hand, an automatic scrubber, or hand held buffer used in conjunction with a detergent.
2. Scuff marks can be removed using an abrasive cleanser.
3. These areas should then be rinsed thoroughly with clean water.

Scratches/Damage
1. Cuts, gouges, and rubber burns such as those caused by fork lifts or sliding heavy equipment across the floor can damage the SRS floor. If this occurs it should be addressed by contacting an approved SRS applicator to make necessary repairs to prevent moisture or contamination from entering the floor.
2. Wax strippers should NEVER be used on an SRS DEGADUR floor. Ammonia mixed with water can remove most waxes.
3. Through the use of proper training and education, unnecessary wear of the floor such as fork lift spin and skid marks can be avoided.
4. Spills should be cleaned up immediately as a safety precaution as well as to prevent staining of the floor.
5. Surfaces should be adequately protected when moving heavy equipment across the floor.
6. Areas that are subject to oil, grease, or harsh contaminants should be degreased and scrubbed on a daily basis.
Attachment C

**WATER CONTAMINATION RESPONSE LOG**

<table>
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<tr>
<th>Field</th>
<th>Details</th>
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<td>Supervisor Notified</td>
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<td>Date and Time of Incident Response</td>
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<tr>
<td>Water Feature or Area Contaminated</td>
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<td>Number of People in Water</td>
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<tr>
<td>Names of people in the water</td>
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<td>Time that Water Feature was Closed</td>
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<td>Total Contact Time</td>
<td></td>
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<tr>
<td>Remediation Procedure(s) Used and Comments/Notes</td>
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</tr>
</tbody>
</table>

(4 readings are spread evenly thru the closure time)

(4 readings are spread evenly thru the closure time)

(Time when disinfectant reached desired level to when disinfectant levels were reduced)
CLINICAL PRODUCT AND DEVICE EVALUATION

POLICY:

Clinical products and devices that are used to render direct patient/resident care require review and approval before being put into routine use at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda).

PURPOSE:

To utilize safe, efficacious and cost-effective clinical products and devices in the care of the residents/patients at Laguna Honda.

PROCEDURE:

1. Before a new clinical product or device may be purchased or introduced at Laguna Honda, the Laguna Honda Product Evaluation Subcommittee of the Pharmacy & Therapeutics Committee must evaluate it. Items that have already been evaluated and selected by San Francisco General Hospital's Product Evaluation Committee may be approved by the Laguna Honda Product Evaluation Committee based on that recommendation or may be subject to additional evaluation.

2. Members of the Product Evaluation Committee include the Director of Materials Management, a physician, a designee from Nursing Administration, a pharmacist, a designee from the Quality Management department, and others by invitation, depending on the product under review. A representative from Facility Services shall participate in equipment decisions when Facility Services will be providing maintenance.

3. Presentations to the Subcommittee Committee may be made by a representative of the subcommittee or the clinician requesting evaluation of a new product. A sales representative may be requested to provide product information in writing or in person at the discretion of the Subcommittee Committee.

4. The Subcommittee Committee may determine that an investigative trial is warranted and will select criteria by which the product will be evaluated. These criteria may be areas such as clinical response, comparative cost to like products, ease of use, and availability. The related product literature, observations made by staff and reported past experience of individuals familiar with the product will be given consideration in making a decision.

5. When a pilot is instituted, a member of the Subcommittee Committee will be identified to coordinate selection of participants, obtain approval of the neighborhood physician and nurse manager as needed, initiate the pilot, collect the
data during a defined time period and make a formal summary report. To promote the most reliable feedback, the Subcommittee will involve in pilot those individuals who have the highest degree of expertise in the area being evaluated.

6. New products should not be piloted on residents/patients whose prognosis is poor to avoid interference with the evaluation process in the event of a negative outcome. An exception may be made to allow the evaluation of palliative care products on terminally ill residents.

7. The Product Evaluation Subcommittee will review new products on an as-needed basis and report to the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee will reflect the products being considered and/or selected in the minutes.

ATTACHMENT:
None

REFERENCE:
None

Revised: 94/12/01, 11/09/27, 15/01/13, 15/11/09 (Year/Month/Day)
Original adoption: 94/11/30
Approved for renumbering from 78-01 to 31-03: 15/01/13
HOSPITAL PARCEL SERVICE

POLICY:

The Hospital will provide all departments with centralized parcel incoming delivery and outgoing shipping services, limited to hospital business.

PURPOSE:

To assure that delivery and shipping services run efficiently and are managed in a cost-effective business environment.

CHARACTERISTICS:

1. Hours of operation:
   a. Incoming
      i. Monday - Friday, 6:30a.m. – 3p.m., excluding major holidays: Parcel delivery companies routinely will deliver to Hospital receiving dock.
      ii. Once daily, Monday - Friday, excluding City holidays: Materials Management will deliver parcels from the receiving dock to departments. Delivery hour may vary with other receiving dock obligations.
   b. Outgoing
      i. Monday - Friday, 6:30a.m. – 3p.m., excluding City holidays: Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) departments must deliver outgoing business parcels directly to the Materials Management Office.

PROCEDURE:

1. Incoming
   a. Storekeeper verifies addressee as Hospital and checks for damages, refusing delivery of damaged packages.
   b. Storekeeper logs each parcel into Hospital log and tallies total.
   c. Storekeeper counts parcels, and after verifying that Hospital's log count and delivery person's count agree, signs delivery receipt.
d. “Refrigeration Required” parcels are delivered immediately to the addressee department and hand transferred to a responsible signatory.

e. “STAT Delivery” parcels that are received before 11:00 a.m. are delivered the same day to the addressee department and hand transferred to a responsible signatory.

“STAT Delivery” parcels that are received after 11:00 a.m. are delivered the following business day to the addressee department and hand transferred to a responsible signatory.

f. Storekeeper delivers to care units/departments and obtains appropriate signature for each parcel. Recipients should retain shipping containers and other materials until they determine that the shipment will not be returned to the vendor.

g. Resident parcels and packages received from the United States Postal Service (USPS) delivered to the Laguna Honda Hospital mailroom will be sorted and delivered to the respective nurse’s station for distribution.

2. Outgoing

a. Shipments should be returned to vendors in original packaging (box, envelope). Departments must provide: Purchase Order number, destination/special return addressee instructions, vendor’s return authorization number, value/insurance instructions.

If vendor will accept return cost, the department must assure that vendor has contacted the parcel service for a "Call Tag," to charge the vendor's own parcel service account. Refer to #4 below.

b. During stated outgoing hours of operation, department delivers outgoing parcels, maximum 100 pounds per box, to Materials Management office.

c. Storekeeper will accept parcel, and will record weight, destination and certain other information in the Hospital log.

d. If the vendor calls the parcel service direct to obtain a "Call Tag" the process normally takes 3-5 days from the date of the vendor’s call to the parcel service, at which time the parcel service will pick up the return shipment at the Hospital dock and will leaves a copy of the "Call tag" as a receipt.

If, after ten (10) business days, no call tag has been issued to Materials Management by the vendor or the department, Materials Management will telephone the user department to advise the department of the impending remand of the un-expedited shipment to the department manager the next
business day. It is solely the department manager's responsibility to resolve call tag issues with its vendors.

e. Storekeeper will secure outgoing parcels and affix the shipping label if the department has not done so. Storekeeper will affix Hospital data and the weight on the parcel.

f. Storekeeper will record in the Hospital log: addressee, address, zone destination, insurance cost, and requester department.

g. Storekeeper will maintain contact with parcel service.

ATTACHMENT:
None

REFERENCE:
None

Most recent review: 12/09/25, 15/11/09 (Year/Month/Day)  
Revised: 98/04/01, 12/09/25  
Original adoption: 94/08/15
INFECTION CONTROL SURVEILLANCE PROGRAM

POLICY:

1. Laguna Honda shall implement an effective process and outcome-oriented infection control surveillance program to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility, to reduce morbidity and mortality and improve resident health outcomes.

2. A risk evaluation shall be performed annually to assess the risks of acquiring and transmitting infections based on the care, treatment and services provided.

3. The annual infection control evaluation shall consider the following factors when performing risk assessment:
   a. demographics and needs of the resident population,
   b. infection rates,
   c. changing pathogens and antimicrobial resistance,
   d. community health events and emerging infectious diseases, and
   e. change in technology, procedures and standards of practice.

PURPOSE:

The objectives of the program include the following:

1. Monitor the occurrence of healthcare associated infections (HAI) and develop intervention strategies to reduce such infections;

2. Detect and investigate clusters of HAI infections or outbreaks and emerging infectious diseases;

3. Evaluate infection prevention and control measures;

4. Observe staff compliance with infection control standards and facility policies and procedures;

5. Identify potential risk factors for infection;

6. Gather and compile HAI data, observe trends and patterns, and determine rates of occurrence;

7. Identify organisms of epidemiologic significance such as tuberculosis and antibiotic-resistant bacteria;
8. Utilize surveillance information to conduct communicable disease contact and exposure investigations (e.g. positive tuberculosis screens); and

9. Meet mandated City, State and Federal reporting requirements based on surveillance data.

PROCEDURE:

1. The responsibility of infection control surveillance is carried out by the Infection Prevention and Control Officer (IPCO). Electronic and or written information is gathered from the following sources:
   a. Microbiology department for culture results;
   b. Pharmacy department for antibiotic orders;
   c. Radiology department for chest x-rays results;
   d. Respiratory care department for nasal swab orders;
   e. Nursing department change of shift reports; and
   f. Resident health records.

2. Every reported case of suspected infection in the skilled nursing facility unit is reviewed by the Infection Control Nurse (IPCO) and a determination is made if the resident has signs and symptoms of infection that meet the McGeer criteria for a healthcare associated infection (HAI) or community acquired infection (CAI).

3. Confirmed cases of HAIs and CAIs are listed on the monthly unit infection control surveillance log and available for review by the clinical care team members.

4. Suspected infections that occur on the acute care units are evaluated based on the Centers for Disease (CDC) National Healthcare Safety Network (NHSN) criteria. NHSN reporting of acute care HAIs and CAIs includes the submission of a monitoring plan and on-going surveillance of antibiotic resistant infections as well as annual influenza vaccination rates for staff. HAIs

5. Monthly surveillance data is aggregated quarterly, and submitted for review by the Infection Control Committee for trends and patterns.

6. Surveillance data on antibiotic resistant organisms such as Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant Enterococcus (VRE) species, Carbapenem-resistant Enterobacteriaceae (CRE), extended spectrum Beta Lactamase (ESBL) Escherichia Coli, and Clostridium difficile are specially
tracked for trends, new incidence, recurrence, colonization and appropriate treatment, possible eradication.

7. Once a year, a multi-disciplinary team; comprised of the Infection Prevention and Control Officer (IPCO) Control Nurse and representatives from Medicine, Nursing, Pharmacy, Out-patient Clinic, and Quality Management Department collaborate on the preparation of an annual infection control report based on surveillance data gathered, observation findings, and other infection control activities performed during the preceding 12 months. The report is submitted annually to the Performance Improvement and Patient Safety (PIPS) Committee and to the Joint Conference Committee for their review and evaluation of the facility’s infection control program.

8. The Infection Control Nurse (IPCO) also conducts weekly observation rounds for staff compliance with hand hygiene, cough etiquette; specialized precautions and general infection control standards wherever resident care activities are carried out and in food preparation areas on a quarterly basis.

9. Findings from weekly surveillance rounds are shared with direct care givers and reported to their respective department managers for follow-up as necessary.

10. Tuberculosis (TB) surveillance stems primarily from daily receipt of AFB reports from the microbiology lab. Contact and exposure investigations are performed as indicated when the Infection Control Nurse (IPCO) is notified for the following circumstances:

   a. Resident has a positive acid fast bacilli (AFB) smear or culture

      b. Employee has a positive TB skin test conversion,

   c. Resident has a new diagnosis of tuberculosis and was not isolated upon admission to the facility

      and or

   d. Employee has a positive TB skin test conversion, in which case the IPCO is informed by occupational health staff, who follow up with the employee.

11. Resident is under the care of the TB Clinic prior to admission to Laguna Honda.

12. Based on infection control surveillance data gathered, the IPCO is responsible for submitting and or preparing the following reports:

   a. Monthly NHSN reporting for infections occurring on the acute care units,

   b. Cases of reportable communicable diseases to the local health officer, and

   c. Outbreaks or undue prevalence of infectious or parasitic disease or infestation to the local health officer and the California Department of Public Health.
ATTACHMENTS:
None

REFERENCE:
LHHPP 25-07 Antimicrobial Management in Acute Medicine At Laguna Honda Hospital

LHHPP 72-01 Tuberculosis Exposure Control Plan

APIC Recommended Practices for Surveillance: Association for Professionals in Infection Control and Epidemiology (APIC), Inc., 2007

CDC/NHSN Surveillance Definitions for Specific Types of Infections Centers for Disease Control (CDC) modified April 2015, retrieved 6/1/15 @ http://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf

McGeer LTCF HAI Criteria (2013)

Revised: 14/03/17, 15/07/30, 15/11/09 (Year/Month/Day)
Original adoption: xx/xx/xx
ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

POLICY:

1. Standard Precautions shall always be followed for all residents regardless of diagnosis. (See Infection Control Policy C2, Standard Precautions)

2. LHH clinicians will utilize the following This policy provides an alphabetical list of diseases and conditions to assist with decisions regarding resident care precautions in accordance with Centers for Disease Control and Prevention (CDC) recommendations.

Body Fluid Standard Precautions must always be followed for all residents regardless of diagnosis.

1. For additional precautions: Nursing and medical staff may implement High Level Respiratory Isolation or Low Level Respiratory Precautions or Contact Precautions according to infection control procedures and will consult with Infection Control Professionals as needed.

3. Infection Control shall be contacted as indicated in when this guideline requires and as needed in order to collaborate in regard to individualized and additional precautions or isolation recommendations. Infection Control is to be consulted when High Level Respiratory Isolation or Special Contact Isolation are being considered. Nursing Operations Managers or on-call physicians may make the decision outside of regular business hours, but may consult off duty Infection Prevention Nurse / Nurse Manager as needed, and must inform infection control on the next business day.

PURPOSE:

To reduce the likelihood of disease transmission, clinical staff shall determines and implement appropriate resident care precautions for all residents.

PROCEDURE:

1. For diseases and conditions requiring Standard Precautions, clinical personnel will care for these residents in the same manner as all hospitalized residents, and no sign shall beis posted. (See Infection Control Policy C2, Standard Precautions)
2. For infections spread by respiratory secretions but for which DropletLow or High Level Airborne Respiratory Precautions are not required, health care providers must wear a mask for respiratory and oral care, in keeping with Standard Precautions.

3. Appropriate signage is required to be posted on or next to the door to the resident’s room for isolation or precautions that are in addition to Standard Precautions.

4. Instructions for each type of isolation / precautions are indicated on the signs, and must be adhered to by all persons entering room.

5. Careful consideration must be given to achieve appropriate room placement to prevent the spread of infection. A private room is necessary for most conditions requiring more than Standard Precautions, unless the resident can be cohort placed in a cohort with someone with a like-condition. In many cases a private room must include a private bathroom, particularly when the pathogen is enteric, such as *C. Difficile* or Norovirus.

6. The Infection Control staff is available for questions or clarification of all resident care precaution guidelines.

7. Diseases requiring a report to the Department of Public Health are reported by Infection Control staff during usual business hours. At other times, the physician or nurse will report if required according to the following table to DPH at 415 554-2830 or, for sexually transmitted diseases to STD clinic at 415 487-5555, or for Tuberculosis, to TB Clinic (415) 206-8524.

6. For infections spread by respiratory secretions but for which Low or High Level Respiratory Precautions are not required, HCW must mask for respiratory and oral care and stress hand hygiene.

7. The Infection Control staff is available for questions or clarification of all resident care precaution guidelines.

ATTACHEMENT:

Alphabetical List of Diseases/Conditions with Required Precautions

Revised: 15/11/09 (Year/Month/Day)

Original adoption:
REMEMBER… **Standard Precautions** are used always, for all residents and all resident care. The following table is to help determine any additional precautions.

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess</td>
<td>Where dressing covers and contains drainage adequately</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where there is no dressing or dressing cannot cover or contain drainage</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION under some circumstances</td>
<td>Until drainage ceases CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Acquired Immune Deficiency Syndrome (AIDS)</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Actinomycosis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adenovirus Infection</td>
<td>In adults - Acute respiratory infection, tonsillitis, pneumonia or kerato-conjunctivitis</td>
<td>Standard Precautions</td>
<td>Duration of illness</td>
</tr>
<tr>
<td></td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION AND LOW LEVEL DROPLET RESPIRATORY ISOLATION</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Amebiasis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td>Cutaneous or pulmonary</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL IMMEDIATELY In the event of potential aerosolizable spores other precautions also needed. DPH Reportable disease</td>
</tr>
<tr>
<td>Arthropod-borne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus)</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Arthropod-borne viral fevers (dengue, yellow fever, Colorado tick fever)</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Ascariasis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspergillosis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL if massive soft tissue infection with copious drainage and repeated irrigations required</td>
<td></td>
</tr>
<tr>
<td>Avian influenza (or other &quot;novel&quot; influenza with a high mortality rate as determined by the CDC or other credible guidelines)</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT ISOLATION PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Babesiosis</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
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<tr>
<td>-----------</td>
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<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Blastomycosis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botulism</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>(see RSV) Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Campylobacter gastroenteritis (See gastroenteritis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Candidiasis</td>
<td>All forms, including oral Standard Precautions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbapenem-Resistant Enterobacteriaceae (CRE)</td>
<td>E. coli, Klebsiella, pneumonia, or Enterobacter, all sites</td>
<td>Private room or cohort with CRE infected or colonized resident</td>
<td>CONTACT INFECTION CONTROL; Assume indefinite colonization; teach resident hand hygiene; Private room or cohort; Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.</td>
</tr>
<tr>
<td>Cat-scratch fever</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Where no drainage or dressing contains drainage adequately</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where dressing cannot cover or contain drainage</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Chancroid</td>
<td>(soft chancre)</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Chickenpox (varicella)</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>Conjunctivitis, genital, respiratory</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL; DPH Reportable disease</td>
</tr>
<tr>
<td>Cholera</td>
<td>(see Gastroenteritis, Cholera)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed cavity infection</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Clostridium infections</td>
<td>C. botulinum</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL, foodborne, or wound DPH Reportable Disease</td>
</tr>
<tr>
<td></td>
<td>C. difficile (—see Gastroenteritis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. perfringens</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Food poisoning or Gas gangrene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coccioidiomycosis (valley fever)</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Causing draining lesions or pneumonia</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Colorado Tick Fever</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Acute bacterial, including Chlamydia, Gonococcal</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute viral (acute hemorrhagic)</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness-CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coxsackie virus disease</td>
<td>(See Enteroviral infections)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creutzfeldt-Jacob disease (CJD)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL IMMEDIATELY!</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Isolation of residents with CJD has not been resolved and will be discussed further at the Infection Control Committee. Residents may need SPECIAL CONTACT AND LOW LEVEL RESPIRATORY PRECAUTIONS (private room, door closed, gown, glove and mask to enter).

**NOTE:** Additional precautions are necessary for handling CJD pathological specimens and contaminated items. CONSULT INFECTION CONTROL.

<table>
<thead>
<tr>
<th>Cryptococcosis</th>
<th>Standard Precautions</th>
<th>CONTACT INFECTION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryptosporidiosis</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>For diapered or incontinent residents unable to maintain hygiene due to dementia or confusion</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cysticerocosis</th>
<th>Standard Precautions</th>
<th>CONTACT INFECTION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytomegalovirus infection immunosuppressed</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
</tbody>
</table>

| Decubitus ulcer (see pressure ulcer sere) | Standard Precautions               |                                       |
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected</td>
<td>SPECIAL CONTACT ISOLATION</td>
<td>Until drainage ceases or can be contained; CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Dengue</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Diarrhea, acute</td>
<td>Special Contact Precautions</td>
<td>Duration of illness CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Cutaneous or Pharyngeal</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>For both forms, isolate until off antimicrobial treatment and culture-negative. CONTACT INFECTION CONTROL IMMEDIATELY</td>
</tr>
<tr>
<td></td>
<td>Low-Level Droplet Respiratory Isolation</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ebola</strong> (viral hemorrhagic fever)**</td>
<td>For persons resident with suspected viral hemorrhagic fever who has screens positive to current Ebola screening questions prominent cough, vomiting, diarrhea, or hemorrhage</td>
<td>SPECIAL CONTACT ISOLATION AND HIGH LEVEL RESPIRATORY ISOLATION</td>
<td>Duration of illness Until transport to approved screening hospital occurs. Notify Nursing Office immediately to initiate Go Team. CONTACT INFECTION CONTROL IMMEDIATELY if not already responded to Go Team overhead page and group page. DPH Reportable disease – REPORT IMMEDIATELY to Communicable Disease Unit (CDU) at 415 554-2830.</td>
</tr>
<tr>
<td>Echinococcosis (Hydatid Disease)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td><strong>Echovirus</strong> (See Enteroviral infections)**</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Encephalitis or encephalomyelitis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Endometritis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Enterobiasis (pinworm disease, oxyuriasis)</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Enterococcus faecalis or faecium, vancomycin-resistant (VRE)</td>
<td></td>
<td>(See VRE) Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SPECIAL CONTACT ISOLATION</td>
<td>SPECIAL CONTACT ISOLATION until three consecutive VRE negative cultures at least one week apart from stool and other areas (i.e., urine) obtained that may be clinically appropriate.</td>
</tr>
<tr>
<td>Enterocolitis</td>
<td></td>
<td>(See Gastroenteritis and C18 Clostridium difficile guideline) Standard Precautions</td>
<td>Duration of diarrhea-CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Enteroviral Infections (i.e. Group A and B Coxsackie viruses and Echo viruses)</td>
<td>Adults</td>
<td>Standard Precautions</td>
<td>Duration of illness</td>
</tr>
<tr>
<td></td>
<td>Incontinent persons</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>
# ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epiglottitis</td>
<td><em>Haemophilus influenzae</em></td>
<td>LOW LEVEL DROPLET</td>
<td>Until 24 hrs after initiation of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RESPIRATORY</td>
<td>appropriate antimicrobial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ISOLATION</td>
<td>therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard Precautions</td>
<td>Note: Respiratory secretions are</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>highly infectious until resident</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>has been on 24 hours of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>appropriate antibiotic therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remember, mask for respiratory and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>oral care. Handwashing stressed.</td>
</tr>
<tr>
<td>Epstein-Barr virus</td>
<td>infection including mononucleosis</td>
<td>Standard Precautions</td>
<td>Respiratory secretions may be very</td>
</tr>
<tr>
<td>(also see Parvovirus B19)</td>
<td></td>
<td>LOW LEVEL DROPLET</td>
<td>highly infectious for 7 days after</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RESPIRATORY</td>
<td>onset of illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ISOLATION</td>
<td></td>
</tr>
<tr>
<td>Erythema</td>
<td>infectiosum</td>
<td>LOW LEVEL DROPLET</td>
<td>Respiratory secretions may be very</td>
</tr>
<tr>
<td>gastroenteritis</td>
<td>(See Gastroenteritis)</td>
<td>RESPIRATORY</td>
<td>highly infectious for 7 days after</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ISOLATION</td>
<td>onset of illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESBL producing organisms</td>
<td>e.g. E. coli or Klebsiella pneumonia, all sites</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>If resident with ESBL has uncontrolled diarrhea or infected sites with fluids which cannot be contained</td>
<td></td>
<td>Assume indefinite colonization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SPECIAL CONTACT ISOLATION</td>
<td>Private room or cohort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continue contact precautions until site of colonization or infection can be appropriately contained and able to maintain hygiene.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Duration of hospitalization – Contact Infection Control if impacting resident rehabilitation</td>
</tr>
<tr>
<td>Food poisoning</td>
<td>Botulism</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Clostridium perfringens</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>or welchi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staphylococcal</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------</td>
<td>------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Furunculosis (staphylococcal)</td>
<td>Adults</td>
<td>Standard Precautions SPECIAL CONTACT ISOLATION</td>
<td>Duration of illness CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Gangrene</td>
<td>Gas gangrene</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>Contact Precautions</td>
<td>Duration of Diarrhea</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>CONTACT PRECAUTIONS if incontinent and unable to maintain hygiene use (for all of the following)</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Adenovirus</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campylobacter</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Cholera</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile (C. diff)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL and EVS upon initiation and termination</td>
<td></td>
</tr>
<tr>
<td>(see also: C18 Clostridium difficile guideline)</td>
<td>CONTACT PRECAUTIONS-ENHANCED with hand washing with soap and water, environmental cleaning with bleach products (Alcohol-based hand sanitizers are ineffective against spores.)</td>
<td>Until resident receives 5 days of antibiotic therapy AND No diarrhea for 48 hours Follow Bleach cleaning policy and procedures including bleach wipes for high touch surfaces</td>
<td></td>
</tr>
<tr>
<td>Escherichia coli, including Enterohemorrhagic 0157:H7</td>
<td>Room placement in private room with private bathroom (or place in cohort with like-cases)</td>
<td>If outbreak or if 0157:H7, CONTACT INFECTION CONTROL DPH Reportable disease CONTACT INFECTION CONTROL DPH Reportable Disease</td>
<td></td>
</tr>
<tr>
<td>Giardia lamblia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norovirus</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Alphabetical List of Diseases/Conditions with Required Precautions

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotavirus</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Salmonella species, including S. typhi</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Shigella species</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Vibrio parahaemolyticus</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Viral (not covered elsewhere)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Yersinia enterocolitica</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable disease</td>
</tr>
</tbody>
</table>

For all of the above gastroenteritis: if incontinent adults unable to maintain hygiene (e.g. due to dementia or confusion)

SPECIAL CONTACT ISOLATION  
Duration of diarrhea CONTACT INFECTION CONTROL
<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>German measles (rubella)</td>
<td></td>
<td>LOW LEVELDROPLET RESPIRATORY ISOLATION PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>

Note: Respiratory secretions are highly infectious until 7 days after onset of rash. Remember, mask for respiratory and oral care. Handwashing stressed.

Giardiasis (see Gastroenteritis, *Giardia lamblia*) | DPH Reportable disease

Gonococcal ophthalmia neonatorium | (Gonorrheal ophthalmia, causing acute conjunctivitis of the newborn) | Standard Precautions | CONTACT INFECTION CONTROL |

Gonorrhea | Standard Precautions | CONTACT INFECTION CONTROL |

Granuloma inguinale | (donovanosis, granuloma venereum) | Standard Precautions

Guillain–Barre syndrome | Standard Precautions

Hand, foot & mouth disease | (See Enteroviral infection)

Hantavirus | Pulmonary syndrome | Standard Precautions | CONTACT INFECTION CONTROL |

Helicobacter pylori | Standard Precautions
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Hemorrhagic fevers</td>
<td>See Ebola for suspected Ebola, Marburg, Lassa, or Yellow Fever (e.g., Lassa, Ebola, Marburg) For resident with suspected viral hemorrhagic fever who has prominent cough, vomiting, diarrhea, or hemorrhage</td>
<td>SPECIAL CONTACT ISOLATION AND HIGH LEVEL RESPIRATORY ISOLATION</td>
<td>Duration of illness — CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease</td>
</tr>
<tr>
<td>Hepatitis, viral infections</td>
<td>Standard Precautions</td>
<td>All hepatitis cases are DPH Reportable Diseases</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A in resident with diarrhea</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness — hospitalization — CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis E</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis, unspecified non-A, non-B</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herpangina</td>
<td>(See Enteroviral infection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herpes simplex infections</td>
<td><em>Herpesvirus hominis</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mucocutaneous, recurrent, localized (skin, oral, genital)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucocutaneous, IF disseminated or severe primary infection</td>
<td><strong>SPECIAL CONTACT PRECAUTIONS</strong></td>
<td>Duration of illness – CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Herpes encephalitis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Herpes zoster (V<em>varicella</em>-zoster, Shingles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Localized zoster</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)</td>
<td><strong>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION</strong></td>
<td>Duration of illness – People susceptible to varicella/chickenpox (employees with no history of chickenpox and no documented positive varicella antibody), pregnant or immunocompromised employees who are antibody negative should not enter the room CONTACT -INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Histoplasmosis</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV (Human immunodeficiency virus)</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease upon initial diagnosis</td>
</tr>
<tr>
<td></td>
<td>Hookworm disease (Anacylostomiasis, Uncinariasis, Necatoriasis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Human immunodeficiency virus</td>
<td></td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Impetigo</td>
<td>Staph, strep, or MRSA</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Until 24 hours after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Note: may occur in adults usually after other infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>Confirmed or highly suspected</td>
<td>LOW LEVEL DROPLET RESPIRATORY ISOLATION, including private room or isolation room (preferred) or cohorting persons with like cases if private/isolation rooms unavailable. Other precautions, such as preventive antiviral therapy for ill resident and resident contacts, generally advised by Infection Control, based upon current CDC guidelines for each flu season.</td>
<td>Until 7 days after onset of symptoms or until 24 hours after resolution of fever and respiratory symptoms, whichever is longer. May be extended longer in immunocompromised residents. CONTACT INFECTION CONTROL 1 case is considered an outbreak in LTC DPH Reportable Disease</td>
</tr>
<tr>
<td>Influenza–like illnesses</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Influenza (culture confirmed or highly suspected)</td>
<td></td>
<td>May need LOW LEVEL RESPIRATORY PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>NOTE:</strong> Respiratory secretions may be highly infectious. Remember, mask upon entering resident’s room for respiratory and oral care. Handwashing stressed!</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> Isolation of residents with culture-confirmed influenza has not been resolved and will be discussed further at the Infection Control Committee. Residents may need LOW LEVEL RESPIRATORY PRECAUTIONS (private room, door closed, mask to enter)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Period of communicability is probably 3-5 days from clinical onset in adults and up to 7 days in young children. During influenza outbreaks, the Infection Control staff may require additional precautions, including cohorting of residents/staff, preventive antiviral therapy, immunizations, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Impetigo</td>
<td>SPECIAL CONTACT ISOLATION</td>
<td>Until 24 hrs after initiation of appropriate antimicrobial therapy; CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Kawasaki syndrome</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Lassa fever</td>
<td>See [Ebola, viral hemorrhagic fever](Hemorrhagic fever)</td>
<td>SPECIAL CONTACT ISOLATION AND HIGH LEVEL RESPIRATORY ISOLATION</td>
<td>Duration of illness – CONTACT INFECTION CONTROL; DPH Reportable disease</td>
</tr>
<tr>
<td></td>
<td>For resident with suspected viral hemorrhagic fever who has prominent cough, vomiting, diarrhea, or hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Infection Control must notify Public Health authorities for any suspected case IMMEDIATELY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legionnaire’s disease</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Leprosy</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL; DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

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<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leptospirosis</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Lice (Pediculosis)</td>
<td></td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Until 24 hours after initiation of pediculosis therapy and no live lice detected. Skin and hair are no longer infested once treated with effective agent.</td>
</tr>
</tbody>
</table>

**Note:** Always wear personal protective gear (i.e., gloves, gowns) for contact with non-intact skin and rashes, especially in the absence of a diagnosis.

| Listeriosis                |                 | Standard Precautions          | CONTACT INFECTION CONTROL                       |
|                            |                 |                               | DPH Reportable disease                         |
| Lyme disease               |                 | Standard Precautions          | CONTACT INFECTION CONTROL                       |
|                            |                 |                               | DPH Reportable disease                         |
| Lymphocytic choriomeningitis|                 | Standard Precautions          | CONTACT INFECTION CONTROL                       |
|                            |                 |                               | DPH Reportable disease                         |
| Lymphogranuloma venerum    |                 | Standard Precautions          | DPH Reportable Disease                         |
| Malaria                    |                 | Standard Precautions          | CONTACT INFECTION CONTROL                       |
|                            |                 |                               | DPH Reportable disease                         |
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
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<tr>
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<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
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</thead>
<tbody>
<tr>
<td>Marburg virus</td>
<td>See Ebola, viral hemorrhagic fever</td>
<td>SPECIAL CONTACT ISOLATION AND HIGH LEVEL RESPIRATORY ISOLATION</td>
<td>Duration of illness – CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>disease</td>
<td>For resident with suspected viral hemorrhagic fever who has prominent cough, vomiting, diarrhea, or hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: Infection Control must notify Public Health authorities for any suspected case IMMEDIATELY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles (rubeola), all presentations</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION</td>
<td>Persons susceptible to measles should not enter room. Employees born after 1957 will be considered susceptible unless they have had physician diagnosed measles or a measles immunization.</td>
<td>Duration of illness. CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease</td>
</tr>
<tr>
<td>Melioidosis</td>
<td>All forms</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>Aseptic (nonbacterial or viral meningitis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL for all forms of meningitis</td>
</tr>
</tbody>
</table>

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### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial, including gram-negative enteric, and neonatal</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Fungal</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td><em>Haemophilus influenzae, type b</em> known or suspected</td>
<td>LOW LEVEL DROPLET _______ Until 24 hrs after initiation of RESPIRATORY _______ appropriate antimicrobial ISOLATION _______ therapy</td>
<td></td>
</tr>
<tr>
<td>Common cause of bronchitis in adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Listeria monocytogenes</em></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td><em>Neisseria meningitis</em> (meningococcal)</td>
<td>LOW LEVEL DROPLET RESPIRATORY ISOLATION</td>
<td>Until 24 hrs after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL DPH Reportable disease</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Standard Precautions</td>
<td>Evaluate for current (active) TB and use High Airborne Level Respiratory Isolation accordingly. Report to TB Control Clinic</td>
</tr>
</tbody>
</table>

Note: Respiratory secretions may be highly infectious until resident has been on 24 hours of appropriate antibiotic therapy. Remember, mask for respiratory and oral care. Hand hygiene imperative washing stressed.
<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other diagnosed bacterial meningitis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (Pneumonia, meningitis, sepsis)</td>
<td>LOW LEVEL DROPLET RESPIRATORY ISOLATION</td>
<td>Untill 24 hrs. after initiation of appropriate antimicrobial therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPECIAL CONTACT ISOLATION during first 24 hrs of antibiotic therapy, then Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td></td>
<td>Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care. Handwashing stressed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------</td>
<td>--------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Meningococcemia (meningococcal sepsis)</td>
<td>LOW LEVEL Until 24 hrs. after initiation of RESPIRATORY appropriate antimicrobial PRECAUTIONS therapy</td>
<td>Standard Precautions CONTACT INFECTION CONTROL</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note: Respiratory secretions may be highly infectious until resident has been on 24 hours of appropriate antibiotic therapy. Remember, mask for respiratory and oral care. Handwashing stressed.</td>
</tr>
<tr>
<td>Molluscum contagiosum</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monkey pox</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Until lesions crusted CONTACT INFECTION CONTROL DPH Reportable Disease</td>
<td></td>
</tr>
<tr>
<td>MRSA (methicillin-resistant Staph aureus)</td>
<td>see Staphylococcus aureus diseases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

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<tbody>
<tr>
<td>Infection Condition</td>
<td>In a body site / fluid where drainage cannot be controlled or adequately contained (residents with pneumonia, bronchitis, copious pulmonary secretions, would drainage not contained by dressing)</td>
<td>SPECIAL CONTACT ISOLATION</td>
<td>Until drainage and/or secretions cease or can be contained, CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>

**Note:** HANDWASHING IS CRITICAL TO PREVENT THE SPREAD OF MRSA!

Ensure hands are clean prior to entering each resident’s room or bedside. Wash hands promptly after contact with residents and residents’ immediate environment. Avoid touching equipment and surfaces with potentially contaminated hands. Incontinent residents colonized with MRSA may be diapered.

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucormycosis</td>
<td>Standard Precautions</td>
<td>Until drainage and/or secretions cease or can be contained</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
</tbody>
</table>

**Multidrug-resistant organisms, infection and/or uncontrolled body fluids**

(See Also Infection Control Manual, 72-01, policy A5, for surveillance plan of current epidemiologically important resistant organisms) SPECIAL CONTACT ISOLATION

(Also sSee Also Infection Control Manual, 72-01, policy A5, for surveillance plan of current epidemiologically important resistant organisms)
<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td>(Infectious parotitis)</td>
<td><strong>Standard Precautions</strong></td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>LOW LEVEL DROPLET RESPIRATORY ISOLATION</strong></td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Respiratory secretions may be highly infectious for 9 days after onset of parotid swelling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://example.com">Remember, mask for respiratory and oral care. Handwashing stressed!</a></td>
<td></td>
</tr>
<tr>
<td>Mycobacteria, Pulmonary or nontuberculosis wound site (atypical)</td>
<td>Standard Precautions</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma pneumonia</td>
<td><strong>LOW LEVEL DROPLET RESPIRATORY ISOLATION</strong></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Necrotizing enterocolitis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neutropenia</strong></td>
<td>Absolute neutrophil count (ANC &lt; 500 per µL or as defined by residents physician)</td>
<td>Neutropenic Precautions, if ordered (The effectiveness of neutropenic precautions is controversial, however some clinicians may put these precautions in place on a case by case basis.)</td>
<td>If clinicians choose NOT to place patient on Neutropenic Precautions then utilize Standard Precautions and restrict ill persons from entering room at least until neutropenia is resolved.</td>
</tr>
<tr>
<td><strong>Nocardiosis</strong></td>
<td>Draining lesions and other presentations</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td><strong>Norwalk agent gastroenteritis Norovirus</strong></td>
<td>(see Gastroenteritis, Viral)</td>
<td>SPECIAL CONTACT ISOLATION CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td><strong>Orf Virus</strong></td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td><strong>Parvovirus B19</strong></td>
<td></td>
<td>Standard Precautions, LOW LEVEL DROPLET RESPIRATORY ISOLATION PRECAUTIONS</td>
<td>Note: Respiratory secretions may be highly infectious for 7 days after onset of illness. Remember, mask when entering resident’s room for respiratory and oral care. Handwashing stressed!</td>
</tr>
<tr>
<td><strong>Pediculosis</strong></td>
<td>(see Lice)</td>
<td>Standard Precautions</td>
<td>Note: Always wear personal protective gear (i.e., gloves, gowns) for contact with non-intact skin and rashes, especially in the absence of a diagnosis! Please refer to C13 Pediculosis protocol.</td>
</tr>
<tr>
<td><strong>Pertussis</strong></td>
<td>(Whooping cough)</td>
<td>Standard Precautions, LOW LEVEL DROPLET RESPIRATORY ISOLATION CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
**ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS**

<table>
<thead>
<tr>
<th>Infection</th>
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<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pinworm infection</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plague</td>
<td>Bubonic</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Pneumonic</td>
<td>LOW LEVELDROPLET RESPIRATORY ISOLATION</td>
<td>Until five-three days after initiation of appropriate antimicrobial therapy</td>
</tr>
<tr>
<td>Pleurodynia</td>
<td>(See Enteroviral infection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Adenovirus</td>
<td>LOW LEVELDROPLET RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness</td>
</tr>
</tbody>
</table>

Note: Respiratory secretions may be highly infectious for 5 days after initiation of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care. Handwashing stressed!
<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia (continued)</td>
<td>Bacterial, not listed elsewhere, including gram-negative bacterial (<em>Enterobacter, Serratia, Acinetobacter sp.</em>)</td>
<td>Standard Precautions</td>
<td>Note: Handwashing is critical after contact with respiratory secretions and items in the resident environment which may be contaminated with respiratory secretions (i.e., ventilator equipment of ICU residents).</td>
</tr>
<tr>
<td>Burkholderia cepacia without in cystic fibrosis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>Avoid cohorting of cystic fibrosis patients colonized with <em>B. cepacia</em></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Fungal pneumonia</td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

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<thead>
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<th>Condition</th>
<th>Type of Precautions</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Haemophilus influenzae</strong></td>
<td>in adults</td>
<td>Standard Precautions</td>
<td>Until 24 hrs. after initiation of appropriate antimicrobial therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care. Handwashing stressed.</td>
<td></td>
</tr>
<tr>
<td><strong>Legionella</strong></td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td><strong>Pneumonia</strong> (continued)</td>
<td>Meningococcal pneumonia</td>
<td><strong>DROPLET RESPIRATORY ISOLATION PRECAUTIONS</strong> and <strong>SPECIAL CONTACT PRECAUTIONS ISOLATION</strong> during first 24 hrs of antibiotic therapy, then Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care. Handwashing stressed.</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>Multi-drug resistant bacteria (see Multi-drug resistant organisms)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Mycoplasma</em> (primary atypical Pneumonia)</td>
<td>Standard Precautions</td>
<td>DROPLET RESPIRATORY ISOLATION PRECAUTIONS</td>
</tr>
<tr>
<td></td>
<td>Note: Respiratory secretions may be highly infectious. Remember, mask for respiratory and oral care. Handwashing stressed!</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Pneumocystis carinii</em> (PCP)</td>
<td>Standard Precautions</td>
<td>Avoid placement in the same rooms with immune-compromised resident</td>
</tr>
<tr>
<td></td>
<td>Note: Avoid placement of resident with PCP in same room with another immune-compromised resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Pseudomonas cepacia</em> (<em>Burkholderia cepacia</em>)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Staphylococcus aureus</em></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Streptococcus, Group A</em></td>
<td>Standard Precautions</td>
<td>DROPLET RESPIRATORY ISOLATION PRECAUTIONS LOW LEVEL RESPIRATORY PRECAUTIONS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Until 24 hrs after initiation of appropriate antimicrobial therapy</td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

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<tr>
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<th>Condition</th>
<th>Type of Precautions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Viral pneumonia, in adults</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia (continued)</td>
<td>Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood and no cough)</td>
<td>LOW LEVEL AIRBORNE RESPIRATORY PRECAUTIONS ISOLATION</td>
<td>Until a respiratory diagnosis is confirmed and TB is ruled out or cough develops (see Policy C-65, High Level Airborne Respiratory Isolation)</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>Standard Precautions SPECIAL CONTACT PRECAUTIONS ISOLATION AND LOW LEVEL DROPLET RESPIRATORY ISOLATION PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer (decubitus)</td>
<td>Infected, where dressing covers and contains drainage adequately</td>
<td>Standard Precautions</td>
<td>Until drainage ceases or can be contained—CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Infected, where there is no dressing or dressing cannot cover or contain drainage</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td></td>
</tr>
<tr>
<td>Psittacosis (ornithosis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Q fever</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
</tbody>
</table>
**ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS**

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<tr>
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<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rabies</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Rat-bite fever</td>
<td>(Streptobacillus moniliformis disease, Spirillum minus disease)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
</tr>
<tr>
<td>Relapsing fever</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
<td></td>
</tr>
<tr>
<td>Resistant bacterial infection or colonization</td>
<td>(See Multi-drug resistant organisms)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Respiratory infectious disease</td>
<td>Acute, in adults</td>
<td>Standard Precautions</td>
<td>Note: Respiratory secretions may be highly infectious for duration of illness. Remember, mask for respiratory and oral care. Handwashing stressed!</td>
</tr>
<tr>
<td>Respiratory syncytial virus (RSV), immunocompromised adults</td>
<td>DROPLET RESPIRATORY ISOLATION PRECAUTIONS and SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Precautions include secretion containment and contact protective personal equipment (gown, golve and mask and gloves to enter. Provide private room with door closed). Respiratory secretions may be highly infectious for duration of illness. Remember, mask for respiratory and oral care.

During outbreaks, the Infection Control staff may require additional precautions, including cohorting of residents/staff, etc.
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reye’s syndrome</td>
<td></td>
<td>Standard Precautions</td>
<td>DPH Reportable disease</td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Rickettsial fevers, tick-borne</td>
<td>(non-Rocky Mountain spotted fever, tick-borne typhus fever)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Rickettsialpox</td>
<td>(Vesicular rickettsiosis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Ringworm</td>
<td>(Dermatophytosis, dermatomycosis, tinea)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
</tbody>
</table>

**Ritters Disease (see Staphylococcal disease, Scalded Skin Syndrome)**

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocky Mountain spotted fever</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Rotavirus infection</td>
<td>(See Gastroenteritis)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>(German measles)</td>
<td>LOW LEVEL DROPLET RESPIRATORY ISOLATION PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
</tbody>
</table>

Note: Respiratory secretions are highly infectious until 7 days after onset of rash. Remember, mask for respiratory and oral care. Handwashing stressed.

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salmonellosis</td>
<td>(See Gastroenteritis, <em>Salmonella</em> species)</td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
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<tr>
<th>Infection Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SARS - Severe acute respiratory syndrome</strong></td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
</tr>
<tr>
<td>Scabies</td>
<td>Standard Precautions SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Skin no longer infested 24 hours after treatment with effective scabicide agent. Stress handwashing. Until 24 hrs. after treatment with effective agent.</td>
</tr>
<tr>
<td>Norwegian scabies</td>
<td>SPECIAL CONTACT PRECAUTIONS ISOLATION PRIVATE ROOM</td>
<td>Maintain isolation until negative skin scrapings obtained by qualified individual.</td>
</tr>
<tr>
<td>Scalded skin syndrome</td>
<td>See Staphylococcal, Ritter’s disease, scalded skin syndrome</td>
<td></td>
</tr>
<tr>
<td>Schistosomiasis (bilharziasis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Shigellosis (See Gastroenteritis, <em>Shigella</em> species)</td>
<td></td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
</tr>
<tr>
<td>Shingles (zoster, varicella zoster)</td>
<td>Localized zoster Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Infection Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness. People susceptible to varicella/chicken pox (employees with no hx of chicken pox and no documented positive varicella antibody, pregnant or immunocompromised employees who are antibody negative) should not enter room. Maintain isolation until lesions dried and crusted.</td>
</tr>
<tr>
<td>Smallpox Suspected or confirmed smallpox</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>CONTACT INFECTION CONTROL Maintain isolation until lesions dried and crusted. DPH Reportable Disease</td>
</tr>
<tr>
<td>Sporotrichosis</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td><em>Spirillum minus</em> disease</td>
<td>See Rat-bite fever</td>
<td>Standard Precautions</td>
</tr>
<tr>
<td><em>Staphylococcus aureus</em> disease</td>
<td>Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately (S. aureus)</td>
<td>Standard Precautions</td>
</tr>
<tr>
<td></td>
<td>Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately</td>
<td>Standard Precautions</td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
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<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage</td>
<td><strong>SPECIAL CONTACT PRECAUTIONS</strong></td>
<td>Until drainage ceases or can be contained –</td>
</tr>
<tr>
<td></td>
<td>MRSA (Methicillin-resistant S. aureus) in body site / fluid where drainage is adequately contained</td>
<td>Standard Precautions</td>
<td><strong>Note:</strong> HAND HYGIENE WASHING IS CRITICAL TO PREVENT THE SPREAD OF MRSA TO OTHER RESIDENTS!</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ensure hands are clean prior to entering each resident’s room or bedside. Wash hands promptly after contact with residents and residents’ immediate environment. Avoid touching equipment and surfaces with potentially contaminated hands.</td>
</tr>
<tr>
<td></td>
<td>MRSA (Methicillin-resistant S. aureus) in body site / fluid where drainage cannot be controlled or adequately contained</td>
<td><strong>SPECIAL CONTACT PRECAUTIONS</strong></td>
<td>Until drainage and/or secretions cease or can be contained – CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>Staphylococcal pneumonia</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scalded skin syndrome (Ritter’s disease)</td>
<td><strong>SPECIAL CONTACT PRECAUTIONS</strong></td>
<td>Duration of illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ISOLATION</td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

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<th>Type of Precautions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Toxic shock syndrome</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable Disease</td>
</tr>
</tbody>
</table>

**Streptobacillus moniliformis disease**

(See rat-bite fever)

<table>
<thead>
<tr>
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<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
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</thead>
<tbody>
<tr>
<td>Streptococcal disease, Group A</td>
<td>Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately</td>
<td>Standard Precautions</td>
<td>Report to DPH when outbreak or single case in food handlers or dairy workers.</td>
</tr>
</tbody>
</table>

**Endometritis (puerperal sepsis)**

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage</td>
<td>SPECIAL CONTACT PRECAUTIONS</td>
<td>Until drainage ceases or can be contained – CONSULT INFECTION CONTROL</td>
<td></td>
</tr>
</tbody>
</table>

**Pneumonia**

(See Pneumonia)
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongyloidiasis</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>Skin and mucous membrane, including congenital, primary, secondary, latent (tertiary), and seropositivity without lesions</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease to STD clinic</td>
</tr>
<tr>
<td>Tapeworm disease</td>
<td>Including <em>Hymenolepis nana</em>, <em>Taenia solium</em> (pork), and others</td>
<td>Standard Precautions</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
</tr>
<tr>
<td>Tinea</td>
<td><em>(Athlete’s foot, fungus infection, dermatophytosis, dermatomycosis, ringworm)</em></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
</tr>
<tr>
<td>Toxic shock syndrome</td>
<td><em>(See Staphylococcal disease)</em></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable disease</td>
</tr>
<tr>
<td>Trachoma, acute</td>
<td></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Trench mouth</td>
<td><em>(Vincent’s angina)</em></td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------</td>
<td>---------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Trichinosis</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trichuriasis</td>
<td>(Whipworm disease) Standard Precautions</td>
<td></td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Mycobacterium tuberculosis</td>
<td>Varies based upon location of disease, clinical symptoms, stage or treatment; as follows:</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Pulmonary, confirmed or suspected, including laryngeal disease</td>
<td>AIRBORNE RESPIRATORY ISOLATION</td>
<td>Discontinue isolation only when TB resident on effective therapy (usually two weeks after start of appropriate therapy; extended if subclinical drug regimen), improving clinically, and resident has three consecutive negative sputum smears, collected on different days, or TB is ruled out.</td>
<td></td>
</tr>
<tr>
<td>Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood)</td>
<td>AIRBORNE RESPIRATORY ISOLATION</td>
<td>Until a respiratory diagnosis is confirmed</td>
<td></td>
</tr>
</tbody>
</table>
### ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra pulmonary TB, no draining lesion, including scrofula (TB infection of lymph nodes in the neck)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Extra pulmonary TB meningitis</td>
<td>Standard Precautions</td>
<td>Note: Resident should also be evaluated for current (active) pulmonary TB. If evidence exists, Airborne precautions necessary (see Tuberculosis)</td>
<td></td>
</tr>
<tr>
<td>Skin-test positive, with no evidence of current pulmonary disease</td>
<td>Consider TB Clinic referral if any suspicion especially for immunocompromised (symptoms may be masked) Airborne Respiratory Isolation while ruling out pulmonary TB; Standard Precautions once cleared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tularemia</td>
<td>Including draining lesions and pulmonary presentations</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td><em>(Salmonella typhi, See Gastroenteritis)</em></td>
<td>Standard Precautions</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Infection</td>
<td>Condition</td>
<td>Type of Precautions</td>
<td>Notes / Reporting Required</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Typhus (Louse-borne typhus)</td>
<td><em>Rickettsia typhi</em></td>
<td>Standard precautions</td>
<td>DPH Reportable Disease</td>
</tr>
<tr>
<td>Urinary Tract Infections</td>
<td>UTI; including pyelonephritis, with or without urinary catheter</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Vancomycin resistant Enterococcus (VRE)</td>
<td><em>Enterococcus faecalis</em> or <em>faecium</em></td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL</td>
</tr>
<tr>
<td></td>
<td>If resident with VRE has uncontrolled diarrhea or infected sites with fluids which cannot be contained</td>
<td>CONTACT INFECTION CONTROL</td>
<td>Assume indefinite colonization. Private room or cohort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.</td>
</tr>
<tr>
<td>Vancomycin-resistant <em>S. aureus</em> (VRSA) or VISA</td>
<td>CONTACT PRECAUTIONS</td>
<td>Duration varies; CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
</tbody>
</table>
| Note: Infection Control must notify Public Health authorities for any suspected case IMMEDIATELY
<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (Chickpox)</td>
<td>Confirmed or suspected case</td>
<td>AIRBORNE RESPIRATORY ISOLATION And CONTACT PRECAUTIONS</td>
<td>CONTACT INFECTION CONTROL Maintain isolation until lesions are crusted. Susceptible persons should not enter the room</td>
</tr>
<tr>
<td></td>
<td>Susceptible persons exposed to chickenpox</td>
<td>AIRBORNE RESPIRATORY ISOLATION</td>
<td>Susceptible persons exposed to chickenpox must be isolated days 10 through 21 post exposure. Report Varicella-related deaths to DPH</td>
</tr>
<tr>
<td>Vibrio parahaemolyticus</td>
<td>(See Gastroenteritis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vincent’s angina</td>
<td>(see Trench mouth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viral disease, respiratory (See Respiratory Infectious disease, acute)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diseases not covered elsewhere</td>
<td>Standard Precautions</td>
<td></td>
</tr>
</tbody>
</table>
# Alphabetical List of Diseases/Conditions with Required Precautions

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>(See Respiratory infectious disease, acute)</td>
<td>Note: Respiratory secretions may be highly infectious for duration of illness. Remember, mask for respiratory and oral care.</td>
<td>DROPLET RESPIRATORY ISOLATION</td>
<td>Until 5 days after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL DPH Reportable disease</td>
</tr>
<tr>
<td>Whooping cough (Pertussis)</td>
<td></td>
<td>DROPLET RESPIRATORY ISOLATION</td>
<td>Until 5 days after initiation of appropriate antimicrobial therapy.</td>
</tr>
<tr>
<td>Wound infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage</td>
<td>CONTACT PRECAUTIONS</td>
<td>Until drainage ceases or can be contained – CONTACT INFECTION CONTROL</td>
<td></td>
</tr>
<tr>
<td>Yersinia enterocolitica (See Gastroenteritis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster (Shingles, varicella zoster)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized zoster</td>
<td>Standard Precautions</td>
<td>Duration of illness</td>
<td></td>
</tr>
</tbody>
</table>
## ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

<table>
<thead>
<tr>
<th>Infection</th>
<th>Condition</th>
<th>Type of Precautions</th>
<th>Notes / Reporting Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disseminated zoster</td>
<td>AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS</td>
<td>Duration of illness. People susceptible to varicella (chicken pox) should not enter room. Maintain isolation until lesions dried and crusted.</td>
<td></td>
</tr>
<tr>
<td>Zygomycosis (Phycomycosis mucormycosis)</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubercolosis (TB)</td>
<td>Mycobacterium tuberculosis</td>
<td>Varies based upon location of disease, clinical symptoms, stage or treatment; as follows: CONTACT INFECTION CONTROL DPH Reportable disease (TB Control)</td>
<td>Discontinue isolation only when TB resident on effective therapy (usually two weeks after start of appropriate therapy; extended if subclinical drug regimen), improving clinically, and resident has three consecutive negative sputum smears, collected on different days, or TB is ruled out.</td>
</tr>
<tr>
<td>Pulmonary, confirmed or suspected, including laryngeal disease</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood)</td>
<td>LOW LEVEL AIRBORNE RESPIRATORY ISOLATION PRECAUTIONS</td>
<td>Until a respiratory diagnosis is confirmed (see Policy C7 Low Level Droplet Respiratory Precautions)</td>
<td></td>
</tr>
<tr>
<td>Disease/Condition</td>
<td>Precautions</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Extrapulmonary TB, no draining lesion, including scrofula (TB infection of lymph nodes in the neck)</td>
<td>Standard Precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extrapulmonary TB meningitis</td>
<td>Standard Precautions</td>
<td>Note: Resident should also be evaluated for current (active) pulmonary TB. If evidence exists, Airborne precautions necessary (see Tuberculosis)</td>
<td></td>
</tr>
<tr>
<td>Skin-test positive, with no evidence of current pulmonary disease</td>
<td>Consider TB Clinic referral if any suspicion especially for immunocompromised (symptoms may be masked). Airborne Respiratory Isolation while ruling out pulmonary TB; Standard Precautions once cleared</td>
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<td>Tularemia Including draining lesions and pulmonary presentations</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
<td></td>
</tr>
<tr>
<td>Typhoid fever (Salmonella typhi, See Gastroenteritis)</td>
<td>Standard Precautions</td>
<td>CONTACT INFECTION CONTROL DPH Reportable Disease</td>
<td></td>
</tr>
<tr>
<td>Typhus (Louse-borne typhus)</td>
<td>Rickettsia typhi</td>
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<td>UTI; including pyelonephritis, with or without urinary catheter</td>
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<td></td>
</tr>
</tbody>
</table>
Vancomycin-resistant Enterococcus faecalis or faecium (VRE)

If resident with VRE has uncontrolled diarrhea or infected sites with fluids which cannot be contained

**Standard Precautions**

**SPECIAL CONTACT PRECAUTIONS**

**ISOLATION**

Private room or cohort with VRE infected or colonized residents

**CONTACT INFECTION CONTROL**

Assume indefinite colonization.

Private room or cohort

Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.

Until culture negative obtained when resident off antibiotic therapy, or drainage ceases at infected site, or resident no longer incontinent if only colonized in GI/GU tract.

Note: HANDWASHING IS CRITICAL TO PREVENT THE SPREAD OF VRE TO OTHER RESIDENTS AND OTHER ENVIRONMENTAL SURFACES!

Place VRE colonized residents in single rooms or in the same room as other residents with VRE. When this is not possible, place near low risk residents—ambulatory, well-nourished, no open wounds, no invasive devices, no high dose steroids or immunosuppressive therapy. Ensure hands are clean prior to entering each resident's room. Wash hands promptly after contact with residents and residents' immediate environment. Avoid touching equipment and surfaces with potentially contaminated hands. Incontinent residents must be diapered.

Vancomycin-resistant S. aureus (VRSA) or Vancomycin-intermediately resistant S. aureus (VISA)

**SPECIAL CONTACT PRECAUTIONS**

**ISOLATION**

Duration varies; **CONTACT INFECTION CONTROL**
<table>
<thead>
<tr>
<th>Disease</th>
<th>Precautions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (Chickpox)</td>
<td>Confirmed or suspected case</td>
<td>High level airborne respiratory isolation and special contact precautions isolation. Maintain isolation until lesions are crusted. Susceptible persons should not enter the room.</td>
</tr>
<tr>
<td></td>
<td>Susceptible persons exposed to chickenpox</td>
<td>Temporary isolation High level airborne respiratory isolation. Susceptible persons exposed to chickenpox must be isolated days 10 through 21 post exposure. Notify infection control. Report Varicella-related deaths to DPH.</td>
</tr>
<tr>
<td>Vibrio parahaemolyticus</td>
<td>(See Gastroenteritis) Vibrio parahaemolyticus (See Gastroenteritis)</td>
<td>DPH reportable disease. Standard precautions.</td>
</tr>
<tr>
<td>Vincent’s angina</td>
<td>(See Trench mouth) Vincent’s angina (see Trench mouth)</td>
<td>Standard precautions.</td>
</tr>
<tr>
<td>Viral disease, respiratory (See Respiratory Infectious disease, acute)</td>
<td>Adults, Diseases not covered elsewhere (See Respiratory infectious disease, acute)</td>
<td>Standard precautions. Note: Respiratory secretions may be highly infectious for duration of illness. Remember, mask for respiratory and oral care. Handwashing stressed.</td>
</tr>
<tr>
<td>Disease/Condition</td>
<td>Precautions</td>
<td>Duration</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<tr>
<td>Whooping cough (Pertussis)</td>
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<td>SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
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<td>Standard Precautions</td>
<td>Duration of illness</td>
</tr>
<tr>
<td>Disseminated zoster</td>
<td>HIGH LEVEL AIRBORNE RESPIRATORY ISOLATION AND SPECIAL CONTACT PRECAUTIONS ISOLATION</td>
<td>Duration of illness. People susceptible to varicella (chicken pox) should not enter room. Maintain isolation until lesions dried and crusted.</td>
</tr>
<tr>
<td>Zygomycosis (Phycomycosis mucormycosis)</td>
<td>Standard Precautions</td>
<td></td>
</tr>
</tbody>
</table>
SMOKE and TOBACCO FREE ENVIRONMENT

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) to maintain a smoke and tobacco free environment consistent with City regulation for the protection and preservation of the health of residents, employees, volunteers and visitors.

2. This policy applies to smokable and tobacco products, including e-cigarettes, nicotine, non-nicotine and chewing tobaccos.

3. Buying and selling of smokable and tobacco products between residents is prohibited.

4. The prohibition of smoking applies to all persons on the Laguna Honda campus.

5. During off campus resident related activities:
   a. Residents are expected to comply with this policy and according to their care plan.
   b. Employees shall comply with this policy when on work time.

DEFINITION:

The campus of Laguna Honda Hospital and Rehabilitation Center refers to areas that include the buildings, grounds, parking spaces bordered by Laguna Honda Boulevard, Woodside, Idora and Clarendon and includes Hospital operated vehicles.

PURPOSE:

1. To promote a smoke and tobacco free environment;

2. To comply with state and/or local regulations which promote a smoke free work environment;

3. To ensure a healthy, comfortable and safe environment; and

4. To provide leadership, guidance and support in the promotion of a healthy lifestyle.

PROCEDURE:

1. Signage

   a. Signs that advise that Laguna Honda is a smoke and tobacco free campus shall be posted at the hospital’s public entrances.
2. Applicability

a. Resident Notification, Assessment and Care Planning

i. Applicants and referral sources shall be informed by receipt of the referral packet that Laguna Honda campus is a smoke and tobacco free environment.

ii. New residents are given the Smoke and Tobacco Free Environment Policy by Admissions and Eligibility staff at the time of the resident’s admission or as soon thereafter as is reasonable.

iii. The resident or surrogate decision-maker acknowledges receipt of the Smoke and Tobacco Free Environment policy and agrees to abide by its requirements by their signature on the Admission packet.

iv. The physician and/or the licensed nurse shall document the resident’s smoking and tobacco use history.

v. When indicated, a designated member(s) of the RCT shall provide the resident with smoking cessation education and therapies.

vi. Assessment and education about smoking and smoking cessation shall be documented in the resident's medical records.

vii. Clinical care plan interventions shall be developed for those residents who are at risk for unsafe smoking and have violated the smoking policy, and may include,

- Smoking cessation
- Search for smoking materials
- Confiscation of smoking materials
- Search of person, belongings and resident room for, and confiscation of, smoking materials
- Meeting with RCT members to discuss the violation with resident and outline care plan to prevent further smoking violations, which may include repeat searches, engagement in smoking cessation activities referral to SATS and/or MD.

viii. Those residents who are identified as smokers, who would like to quit smoking shall be offered smoking cessation education and will be evaluated for appropriate therapies with a goal of smoking cessation.

b. Employee and Volunteer Notification

i. Job posting announcements shall include a statement informing applicants that the Laguna Honda campus is a smoke and tobacco free environment.
ii. Employees, volunteers, including trainees and students, shall be notified during orientation that smoking is not permitted on the hospital campus.

iii. To facilitate a smoke and tobacco free environment, designated staff shall periodically offer smoking cessation programs for employees.

c. Visitor Notification

i. Visitors, including contractors, vendors and outpatients, shall be informed that the Laguna Honda campus is a smoke and tobacco free environment through signage at entrances, applicable agreements, hospital and hospital brochures and by staff.

3. Compliance

a. The entire Laguna Honda community is responsible for complying with the Smoke and Tobacco Free Environment Policy which may include respectfully informing the smoker that Laguna Honda is a smoke and tobacco free campus.

b. The smoke and tobacco free environment policy is part of the new employee orientation and annual in-service.

c. An employee who observes a smoking violation by a resident is to report the incident to the respective neighborhood nurse manager/charge nurse.

d. An employee who observes a smoking violation by a staff member is encouraged to report the incident to the responsible manager for corrective action.

e. The Resident Care Team shall review the care plans of residents who are not complying with the terms of this policy to determine if further interventions can be provided to assist the resident with compliance.

f. An employee who violates this policy may be subject to disciplinary action.

g. Sheriff Officers who observe noncompliance or are contacted to assist with notifying residents, visitors or employees to comply with this policy may cite the noncompliant smoker for violation of municipal or state codes.

h. The smoke patrol and others are to report smoking violations to the Nursing Office.

h. Employees may call the Laguna Honda Smoke Free Campus Phone Message Line (415-682-5678 or ext. 45678) for the following options:

   ● Report a smoking violation
Leave a comment or question
Smoking cessation resources
Laguna Honda smoke free campus statement
A script for talking to those violating the smoking policy
Current Harmony Park hours

i. RCT will address resident’s non-compliance by assessing and implementing appropriate interventions.

ATTACHMENT:
None

REFERENCE:
LHHPP 35-01 Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus
CDPH Program Flexibility, Requested 01/13/2014
Smoking Cessation Assessment (MR 161T)

Revised: 98/01/01, 08/10/01, 08/11/25, 10/04/13, 11/11/29, 14/01/28, 15/11/09
(Year/Month/Day)
Original adoption: 92/10/30
STUDENT AFFILIATIONS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) supports the development of future professionals by providing opportunities for students from academic programs to receive job-related experiences.

PURPOSE:

To provide a safe and supportive educational experience for students, as future health care providers, in a manner that enhances Laguna Honda's mission and practices.

PROCEDURE:

1. Students must be enrolled in an approved academic program with a current student affiliation agreement with the Department of Public Health.

2. Student placement is made through the affiliating department head or departmental site coordinator after verification that a current student placement agreement exists with the DPH Office of Contract Management and Compliance.

3. New agreements may be initiated by school faculty contacting the department head or departmental site coordinator to assure the feasibility of placement, followed by coordination and completion of a new agreement with the DPH Office of Contract Management and Compliance (554-2607).

4. Students and faculty are subject to legal and health requirements as outlined in their agreements and includes signing and adhering to the following:

   a. Health Screening Verification

   b. Residents Rights and Dependent Abuse Reporting Agreement

   c. User Confidentiality, Security and Electronic Signature Agreement Form (for HIPAA privacy rule compliance)

5. Student names, phone numbers, and the above referenced forms must be submitted prior to placement in any area of Laguna Honda.

6. Students will receive orientation that includes the following, in addition to orientation or training outlined in department-specific affiliations policies.

   a. Orientation of faculty who will be supervising on-site to the physical layout, policies and procedures including infection control, blood borne pathogens,
injury prevention, life safety, resident’s rights, abuse prevention and reporting, and HIPAA privacy.

b. Orientation of students, including the topics above, provided by the faculty, departmental site coordinator, or other staff as mutually agreed upon.

c. Orientation programs and student tracking form examples are available on the shared (“N”) drive in the “Student Orientation” folder.

7. Students and faculty must wear their school identification badges when on site. Alternatively, Laguna Honda will provide identification badges if the student must have card key access to fulfill their role.

8. Dictations and / or medical record entries by students need to be counter-signed by the Laguna Honda on-site supervisor.

9. Student documentation in the medical record must be legibly signed by the student, according to departmental policy and in such a manner that the individual can be identified. (e.g. for nursing students, "M. Smith, RN student, UCSF"; for pharmacy students, "M. Smith, PS 4")

10. Students may access information needed to perform their role but are not to remove any information from the premises, nor copy documents with personal health information (PHI), nor photograph residents or documents containing PHI using any device including a cell phone with a camera.

11. Students may not enter PHI onto their personal electronic device(s).

12. Resident's PHI is not to be included in email messages to or from affiliating students or faculty.

13. Generally, DPH email accounts are not issued to affiliating students. Exceptions may be accommodated by IS upon request from the students' Laguna Honda site supervisor or department head when the student is doing significant long-term work for Laguna Honda.

14. Records of student affiliations will be kept in the department in which the student is placed, including a copy of the student signature card and confidentiality agreement. The original student signature card and confidentiality agreement is sent to HIS promptly after the documents are completed. The signature card is an index card with the following:

a. Full printed name

b. Title

c. Name of school
d. Time frame at Laguna Honda Hospital

e. On-site Laguna Honda site coordinator/supervisor

f. 1 or 2 different ways of signing their full name (i.e. M. Smith; Mary Smith)

g. Initials

15. Students may be granted permission to access the electronic resident records and other data independently via a temporary log-in provided by the Information Services (IS) department, depending upon their function at Laguna Honda and related need to know resident information in order to perform their role.

16. Computer access to information is subject to the DPH HIPAA policies and facility polices.

17. Laguna Honda departmental site coordinators act as liaisons to evaluate placement and facilitate resolution of issues that may arise.

18. Student supervision and disciplinary action is the responsibility of the school faculty. The faculty supervisor must be on site while students are present for students placed as a group and as arranged between the faculty and Laguna Honda departmental site coordinator for individual students.

19. At the end of the students’ affiliation period, the Laguna Honda preceptor must promptly notify the IS department to deactivate the student computer log in, if issued. Any other facility access items, such as keys or badges, must be surrendered to the departmental site coordinator on or before the last day of affiliation.

20. Student volunteer policies are addressed separately within the Laguna Honda Volunteer departmental policies and procedures.

ATTACHMENT:
None.

REFERENCE:
LHHPP 21-04 HIPAA Privacy Policy
LHHPP 21-01 Medical Records Information: Confidentiality and release
LHHPP 21-02 Transmission of Confidential Medical Information Via Facsimile
LHHPP 29-02 Resident As Photography or Interview Subject
LHHPP 29-07 Human Subject Research
Activity Therapy Department Policies and Procedure B2.0: Student Internship Program
Nursing Policy and Procedure A5.0: Nursing Educational Affiliations
Occupational Therapy Policy 20-04: Clinical Training for Occupational Therapy Interns
Pharmaceutical Services Policy 01.08.00: Extern Students
Physical Therapy Policy 20-04: Clinical Training for Physical Therapy Interns

DPH Privacy Policy: HIPAA Compliance

Revised: 15/05/08, 15/09/08, 15/11/09 (Year/Month/Day)
Original adoption: 11/09/27
PARKING ON THE LAGUNA HONDA HOSPITAL CAMPUS

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to provide parking for those who have business on the LHH campus. However, parking is limited and not available to everyone who may request it.

2. Parking for eligible staff on the LHH campus is available for a fee as set by the City and County of San Francisco Municipal Code, Administrative Code Section 4.24 Parking Fee For City Parking Facilities, which states:

“The price of a Municipal Railway monthly pass plus $10.00, or the existing amount being charged as of May 31, 2004, whichever is higher.”

3. The City is not responsible for loss or damage to vehicles parked on LHH campus.

4. LHH parking areas are subject to applicable local and State traffic codes.

PURPOSE:

To provide rules and regulations governing parking at the Laguna Honda Hospital campus.

PROCEDURE:

1. Employee Parking and Eligibility

   a. Employees are eligible to purchase permits for parking on the LHH campus on a first come-first serve basis.

      i. Employees must complete and sign:

         • LHH Employee Parking Permit Application
         • Payroll Deduction Parking Fee Application

      ii. If parking space is not available the employee’s name will be added to the wait list in the order received.

2. Motorcycle Parking

   a. Motorcycle/scooter parking is available in designated areas subject to the parking permitting fees based on proration and rules.
b. Employees with an issued permit wanting to use a motorcycle as a secondary mode of transportation may request a motorcycle permit at no additional charge.

3. Disabled Parking

a. Disabled parking is restricted to vehicles properly displaying “Disabled Person” or “Disabled Veteran” plates, placards, parked in disabled designated space only.

b. Employees with valid disabled plates or placards are required to pay the appropriate parking fee & display a valid LHH parking permit.

4. Parking Permit Categories

a. Red – Executive Committee Members and Site Watch Commander designated Site Watch Commander.

   i. Valid in all red designated parking spaces or general staff parking spaces

b. Purple – Staff

   i. Valid in all non-designated parking spaces

c. Black – Physicians

   i. Valid in all black designated parking spaces or general staff parking spaces

d. Blue – Employees exempt from parking fee through MOU

   i. Valid in all non-designated parking spaces

e. Paper Red Holders – requires review annually

   i. Night/Weekend & Clinic MDs

      • Valid in all black designated spaces marked “Clinic MD”

   ii. Executive members with affiliation at LHH but already paying for parking with other entities (permit includes red dot sticker)

      • Valid in all red designated parking spaces

5. Collection of Monthly Parking Permit Fees

a. Employees with parking permits must complete a payroll deduction form.
b. Staff on paid vacation/leave remain responsible for paying their monthly parking fees, which will continue through payroll deduction, to maintain a space on campus. If taking unpaid leave, alternative payments must be arranged in advance. Failure to continue payment will remove the employee from the active list for parking privilege and the open space will be given to the next person on the waiting list.

6. Non-employee Parking and Eligibility

a. Volunteer Parking
   i. Permits are issued by the Volunteer Department
   ii. Parking is restricted to designated areas
   iii. Permits must be renewed every 6 months

b. Temporary Vendor/Auditor Parking
   i. Permits are issued by Materials Management or Administration
   ii. Parking is restricted to 30 days
   iii. Temporary parking permits are valid only for the dates specified. If no dates are specified, the temporary parking permits are valid only for 24 hours from the date of issue.

c. Visitor Parking
   i. Is available for visitors up to 3 hours in designated areas.
   ii. Employees parked in visitor parking will be ticketed.

d. Special Event Parking
   i. Requests for parking for special events must be submitted to Administration one week prior.

7. Enforcement of Parking Permit and Rules

a. Parking Permit Enforcement:
   i. The Sheriff Department enforces and monitors parking on the LHH campus, in compliance with the Department of Parking & Transportation (DPT) and the State of California.
b. Challenging the Issuance of a Parking Citation

   ii. Once a citation has been issued, it is illegal for an officer to void the ticket (ref. Sec 40202 CA Vehicle Code; S.F. Traffic Code Article 8 Sec. 157).

   iii. If an individual wishes to contest a parking ticket he/she may follow the procedures noted on the back of the ticket.

   iv. In addition to the procedures on the back of the citation, an individual may file a request for citation cancellation with the Department of Parking and Traffic through the SF Sheriff’s Department at Laguna Honda Hospital. The ticket will be processed in the manner established by the Department of Parking and Traffic for disputed citations.

b-c. Rules and Regulations

   i. Parking privileges are not transferable; permits may be used only by the individual to whom the permit is issued.

   ii. Permits are invalid when:

       • any portion is not visible or legible,
       • any portion has been altered,
       • the appropriate fee has not been paid,
       • it has been lost, stolen, or cancelled (it must be reported immediately).

   i. Vehicles cannot be “parked” on LHH campus in excess of 72 hours continuously including those with the handicapped placards. Otherwise, the car owners are subject to citation and/or tow.

   ii. Permit holders agree to abide by LHH campus and DPT parking policies. Failure to do so may result in the loss of parking privileges.

   iii. Employees who violate the LHH parking policy may face progressive disciplinary action, including suspension or revocation of parking permit

c-d. Parking Permit Returns

   i. Employees must return their issued permit to the Administration Department in the event that they will no longer be on the LHH campus for business purposes. Reasons to return permits include:

       • Voluntary separation
- Dismissal/termination of employment
- No longer need/want parking permit

8. Laguna Honda Parking Committee Membership and Responsibilities

a. LHH Parking Committee Membership, including staff representative from the following departments appointed by the department head:

   i. Administration
   ii. Medicine
   iii. Facilities
   iv. Finance
   v. Human Resources
   vi. Nursing
   vii. Sheriff
   viii. Others as needed

b. The LHH Parking Committee is responsible for reviewing issues and special requests related to parking on the LHH campus, in accordance with current City Policy and final approval by the LHH Executive Committee.

c. The Chief Operating Officer is responsible for determining changes to the parking that may be affected by campus activity or condition, i.e. on-site construction.
ATTACHMENT:

Appendix A: Employee Parking Permit Application
Appendix B: Payroll Deduction Authorization/Cancellation
Appendix C: SFMTA Administrative Review Form

REFERENCE:
Sec 40202 CA Vehicle Code; S.F. Traffic Code Article 8 Sec. 157
City and County of San Francisco Municipal Code, Administrative Code Sec 4.24
Parking Fee For City Parking Facilities.

SEC. 4.24. PARKING FEE FOR CITY PARKING FACILITIES.

Where the City provides parking to City employees or to City tenants at facilities under the City’s management or control, the City may charge the following monthly fee for parking to those employees or tenants:

The price of a Municipal Railway monthly pass plus $10.00, or the existing amount being charged as of May 31, 2004, whichever is higher.

This section shall not apply to parking facilities under the management or control of the San Francisco Parking Authority, the Airport, or the Port. (Added by Ord. 182-04, File No. 040743, 7/22/2004)

Revised: 15/11/09
Original adoption: 15/09/08
Appendix A: Employee Parking Permit Application

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER
EMPLOYEE PARKING PERMIT APPLICATION

Directions: Please fill out completely, along with the "Payroll Deduction Authorization/Cancellation" form (available on the intranet under the "Parking" icon). Bring both forms to Linda Himel in the Administration Office or fax to 415-759-2374. Please allow up to a week before your name will appear on the waitlist.

<table>
<thead>
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<th>NIGHT ☐</th>
<th>AM ☐</th>
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### Vehicle Information

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<tr>
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<tr>
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--------Internal Use – Do Not Write Below-------------------------------------

<table>
<thead>
<tr>
<th>Permit #:</th>
<th>Tag Color:</th>
<th>Date Issued:</th>
<th>Initials:</th>
</tr>
</thead>
</table>

I ___________________________ have received a copy of Policy 90-04, Parking on the LHH Campus, and accept the provisions of this policy. I have also been informed and accept that the CITY is not responsible for loss or damage to vehicles parked on LHH campus.

Revised 3/10/2015
Appendix B: Payroll Deduction Authorization/Cancellation

Payroll Deduction Authorization/Cancellation Form

If no response after two pay periods, call PPSD. Do not resubmit.

☐ NEW AUTHORIZATION ☐ CHANGE AUTHORIZATION ☐ CANCELLATION

<table>
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<tr>
<th>EMPLOYEE ID</th>
<th>RECORD #</th>
<th>LAST</th>
<th>FIRST</th>
<th>M.I.</th>
<th>DEPT. ID</th>
<th>DEPT. NAME</th>
<th>JOB CLASS</th>
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INDICATE THE DEDUCTION NAME AND DEDUCTION AMOUNT:

- PARKING FEE FOR DPH – LAGUNA HONDA HOSPITAL PRK001
- PARKING FEE FOR LHH MOTORCYCLE/SCOOTER ONLY PRK010

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<th>MONTHLY DEDUCTION AMOUNT</th>
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<td>$</td>
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<tr>
<td>PARKING FEE FOR LHH MOTORCYCLE/SCOOTER ONLY</td>
<td>PRK010</td>
<td>$</td>
</tr>
</tbody>
</table>

☐ NEW AUTHORIZATION

☐ CHANGE AUTHORIZATION

I hereby authorize the Controller of City and County of San Francisco to withhold from each of my salary warrants the deduction amount stated above and to transmit said sum to the organization named above.

I consent to the adjustment of such deduction (1) to conform to future pay period change or (2) reflect any change in union dues of which the Controller may be advised by the organization. This authorization shall be in full force and effect until revoked by the undersigned or by the organization.

Any discrepancies in my voluntary deductions as reported on my pay stub must be reported by me in writing to PPSD, One South Van Ness Ave., 8th floor, San Francisco, CA 94103 within 30 days after the occurrence.

SIGNATURE OF EMPLOYEE

TODAY’S DATE

☐ CANCELLATION—SIGN AND DATE THIS SECTION AND FORWARD TO YOUR UNION, IF APPROPRIATE

Please cancel my payroll deduction as soon as possible.

SIGNATURE OF EMPLOYEE

TODAY’S DATE

AUTHORIZED BY ______________ PHONE ______________ DATE ______________

DO NOT WRITE BELOW THIS LINE

PPSD USE ONLY

PPSD USE ONLY

PREPARED BY ______________ PHONE ______________ DATE ______________

KEYED BY ______________ PHONE ______________ DATE ______________
Appendix C: SFMTA Administrative Review Form

ADMINISTRATIVE REVIEW FORM

SFMTA
Municipal Transportation Agency

Use this form, or your own letter, to request administrative review of a citation(s). Submit protest request within 21 calendar days of the issuance of the citation, or 21 calendar days of the date of the first mailed citation notice. Include copies of any documents that support your statement of facts. Documents submitted cannot be returned. (PLEASE PRINT LEGIBLY)

I PROTEST THIS CITATION(S) FOR THE FOLLOWING REASON:

☐ METER PAID / MALFUNCTION  ☐ CURB PAINT FADED  ☐ MISSING OR OBSCURED SIGN
☐ STOLEN VEHICLE  ☐ SOLD/NOT OWNED YET  ☐ VALID PERMIT / DP DISPLAYED
☐ COMPLIANCE / FIX IT CITATION  ☐ DISCLAIMER  ☐ TRANSIT AND OTHER, EXPLAIN DETAILS:

NAME: __________________________ PHONE: (____)_______ ____________
ADDRESS: ____________________ ZIP: ____________
CITY/STATE: ____________________
EMAIL: __________________________

STATEMENT OF FACTS: (EXPLAIN SPECIFIC DETAILS)

I declare that the foregoing is true and correct:

_____________________________  __________________________
SIGNATURE                     DATE

*MAKE A COPY FOR YOUR RECORDS AND MAIL OR BRING FORM TO:
CITATION REVIEW CENTER – 11 SOUTH VAN NESS AVENUE, SAN FRANCISCO, CA 94103

San Francisco Municipal Transportation Agency | Citations & Permits | 11 South Van Ness Avenue, San Francisco, CA 94103 | Tel: 415.61-3000 | Fax: 415.701.5200 | www.sfmta.com
DOMESTIC HOT WATER MONITORING

POLICY: Watch engineers will maintain the domestic hot water temperature at a control range of 104.5-120 degrees F.

PURPOSE: To provide a hot water temperature range that is safe and comfortable to the patients.

PROCEDURE:

A. Weekdays: The watch engineer will check and record the domestic hot water systems temperature after the mixing valve at the beginning of each shift for each building. The Watch Engineer shall also take and record a temperature reading at a patient sink in each building each shift at designated locations that are specified on the log sheet. Engineers immediately shall report any water temperature readings, which exceed the prescribed range limits to the Senior Engineer and follow his directions. The Senior Engineer shall take immediate corrective actions to resolve the malfunctioning of the hot water temperature controls such as:

1. Check computer control operation.

2. Have the temperature control switched to the local pneumatic system.

3. Notify Nursing Supervisor or Director of Nursing of the excessive temperature.

4. Notify the Senior Engineer of the day crew, Maintenance Supervisor, and Chief Engineer.

B. Weekends, holidays and nights: The Watch Engineer will check the domestic hot water systems temperature using the same locations and procedures as on weekdays. If any excessive temperatures have been discovered the following corrective action shall be taken:

1. Watch engineer to check computer control,

2. Switch temperature control to the local pneumatic system,

3. Notify the Nursing Supervisor or Director of Nursing, and

4. Check the temperature control system and call Senior Engineer. If not available, call Chief Engineer or Director of Facility Services.
C. The Chief Engineer, Senior Engineer, Watch Engineer, respectively, shall notify the Nursing Supervisor when the normal temperature range has been re-established.

D. The Watch Engineer shall run a monitor report on the Insight Apogee of all domestic hot water systems at the midnight. These reports will be kept in a binder and compared by him/her to the Watch Engineer’s readings, any discrepancies shall be reported to the Senior Engineer, who will notify the Chief Engineer.

E.

F. The domestic hot water system will be maintained by the engineers on a monthly basis as outlined in the Preventive Maintenance Program.

G. Evidence of the domestic hot water control malfunctioning shall be reported to the Director of Facility Services in writing by the Chief Engineer or Maintenance Supervisor.
CHARGING OF ELECTRIC WHEELCHAIR BATTERY CHARGING

POLICIES:

1. Electric wheelchairs are charged inside the resident’s room and the living rooms. Electric wheelchairs must not be charged in the great rooms, hallways, and resident’s or neighborhood bath or tub rooms.

2. The P.M. shift staff is responsible for charging electric wheelchairs after 2300 (11:00 P.M.). Do not charge electric wheelchair for more than 8 consecutive hours. Nursing staff will follow safety procedures to prevent electrical or chemical injury and avoid over or under charging of wheelchair battery that may impact battery performance.

3. The A.M. shift staff is responsible for disconnecting the electric wheelchairs when fully charged.

4. The charge nurse or designee notifies the Facility Services for electric wheelchairs needing repair. (e.g., poorly function electric wheelchair, exposed wiring, loose hardware, cracked battery cap, etc.).

   The charge nurse is to keep wheelchair equipment in working order by requisitioning repairs.

   The charge nurse or designee notifies informs the Facility Services:

   for newly admitted resident using an electric wheelchair,
   for electric wheelchairs needing repair e.g., poorly function electric wheelchair, exposed wiring, loose hardware, cracked battery cap, etc.

The P.M. shift plugs the wheelchair charger onto the battery after 2300 (11:00 PM). When the charger indicates that the wheelchair battery is fully charged, A.M. staff disconnects the charger.

The charge nurse is to notify the Superintendent of Building and Grounds when there is a change in the number of electric wheelchairs on the neighborhood. Buildings and Grounds department checks batteries and adds water when needed.

PURPOSE:

To maintain electric wheelchair equipment in operable condition and ensure resident’s and staff safety.

BACKGROUND:

Electric wheelchairs are propelled by motor or battery. In order to work properly, electric wheelchair batteries are required to be charged.

Types of Chargers

- Tapering type (with a timer) starts with a high-charge rate and gradually tapers off, stabilizing at full charge. Follow directions in setting the times; if it is set for too long a period following minimal use of the chair, the battery can be overcharged.

- Automatic type shuts off almost completely when the battery reaches full charge.
2. Charging Precaution

   a. During charging, energy is stored in a battery by conversion of part of the water into acid. After a battery is fully charged, extra energy input is not stored but rather converts battery water into gases that bubble out and escape.

   b. Overcharging

      i. Can increase the battery’s risk of explosion. Liquid inside the battery cells bubble vigorously and develops hydrogen and oxygen gases.

      ii. Is the number-one cause of battery failure in deep-cycle service and is always caused by improper use of a battery charger.

      iii. Results in excessive heat, warped and broken plates, damaged separators, severe shedding of active materials from the plate, and excessive evaporation of water which allows the plate to dry out.

   c. Undercharging can diminish charging capacity of battery.

PROCEDURE:

A. Battery Charging

   1. Charging Precautions

      a. Avoid over or under charging wheelchair battery as this may impact battery performance.

      b. Overcharging the battery increases the battery’s risk of explosion, overheating, and battery failure.

      c. Undercharging the battery decreases the electric wheelchair power.

    1. A battery should be charged for a comparable number of hours that the battery was in use. Charging time varies with such factors as voltage at the outlet, temperature, battery size and condition. Only charge wheelchair batteries for not more than 8 consecutive hours. Electric wheelchair can be charged at anytime when not in use.

    2. Electric wheelchairs can be charged inside (exception great room, hallway, and bathroom).

    3. Keep cap securely in place to avoid chemical exposure. Do not to open or remove battery caps to add water at any time.

    4. Equipment in need of mechanical repair will be removed from the neighborhood until it has been repaired for repair.

    5. Observe for any telltale clues of overcharging:

      a. If the top of the battery tends to be wet, especially after a long hard period of use.

      b. If water has to be added frequently.

    6. Keep battery away from sparks, lighted cigarettes and open flames.

B. Chemical Exposure Management Additional Safety Precautions
Charging of Electric Wheelchair: Battery Charging

1. Do not remove battery caps. Keep caps securely in place to prevent the inadvertent splashing of the corrosive sulfuric acid which can damage skin, muscle, fatty tissue, metals, cloth, and floor.

2. If the acid does splash onto the skin:
   a. Wash immediately with large amounts of running water.
   b. Contact supervisor and Industrial Hygienist immediately.
   c. Refer to MSDS.
   d. Complete work injury report

   b. Baking soda is helpful in neutralizing the acid in cases where it cannot be washed away entirely, but it is not a substitute for thorough initial washing with water.

3. Hardware must hold the battery housing and lid securely in place. A loose battery can bounce around and its case might crack. Tighten the hardware evenly from each end but do not overtighten. Be sure battery terminals are tight. Loose connections can cause intermittent electrical power to the motor.

4. Report immediately to Facility Services any loose or exposed wiring or loose hardware which holds battery in place.

CROSS REFERENCES:

LHH/PP 71-03 Electrical Equipment Safety Program
Facility Services P&P EM-1 Equipment Management Program
Facility Services P&P EM-10 Wheelchair Maintenance and Repair
MSDS
Industrial Accident P&P

Revised: 8/2000, 07/31/2012; __________11/10/2015
Reviewed: 07/31/2012_________11/10/2015
Approved: __________
VITAL SIGNS

POLICIES:

1. Any nursing staff member except Home Health Aide, Licensed Nurse (LN), Certified Nursing Assistant (CNA), and Patient Care Assistant (PCA) may perform vital signs (V/S) measurements based on their demonstrated competency or scope of practice.

2. Vital signs include blood pressure (BP), pulse rate (PR), respiratory rate (RR), temperature (T), and oxygen saturation (O2 sat), and pain intensity.

3. Orthostatic VS are measured as per policies and procedures, as per physician’s order, and whenever clinically indicated based on the assessment of the licensed nurse.

4. Vital signs (excluding RR and pain score) are measured using automated V/S machine. Temperature is to be checked via tympanic thermometer in all residents. Licensed nurse can also verify BP using manual sphygmomanometer when needed.

5. For residents whose reimbursement for SNF care is Medicare, V/S should be taken and recorded at least daily. In long-term care neighborhoods, V/S are checked monthly at a minimum, unless otherwise ordered. For residents whose reimbursement for SNF care is Medicare, vital signs should be taken and recorded at least daily.

6. Residents receiving certain cardiovascular or antihypertensive medications are monitored as per Medication Administration procedure.

7. Residents in isolation rooms will have designated automated V/S machine and tympanic thermometer available. When available, individual BP cuffs are kept at the resident's bedside.

   The use of individualized BP cuffs is encouraged. When not able to use an individualized BP cuff, using the multi-used BP cuffs, and clean the cuffs in between resident use with facility approved disinfectant, otherwise use individualized BP cuffs.

PURPOSE:

To outline frequency of vital sign measurement and nursing responsibilities.

PROCEDURES:

A. Equipment

   Automated V/S Machine
   Individual BP cuffs or Multi-Use Cuffs
   Manual Sphygmomanometer
   Tympanic thermometer

B. Frequency of Monitoring V/S
Vital Signs

1. Refer to procedures delineated in approved textbooks for nursing assistants and nurses. Vital signs are routinely measured as follows:

   a. Admission for all SNF Neighborhoods: V/S are taken upon admission to any neighborhood in LHH with at a minimum of every 8 hours for the first three (3) days, unless otherwise ordered. Orthostatic BP/PR is done once as part of the admission nursing assessment to evaluate for hypotension and whenever clinically indicated.

   a.b. Specific Acute Neighborhood Units:
      - Pavilion Mezzanine Acute (Medical): upon admission and every four (4) hours, or and more frequently as clinically indicated.
      - Pavilion Mezzanine Acute (Rehab): every eight (8) hours for first three (3) days after admission V/S and then daily or and as clinically indicated.
      - Positive Care Neighborhood: every 8 hours for first 3 days after admission V/S, and when as clinically indicated.
      - Pavilion Mezzanine SNF and SNF Neighborhood: after admission V/S every 8 hours for first 3 days, and when as clinically indicated.
      - Long Term SNF Neighborhood: after admission V/S and as clinically indicated.

   b. Discharge: before discharge from Pavilion Mezzanine Acute or to outside acute facility or hospital.

   c. Relocation from one neighborhood to another within LHH: every 8 hours for the first 3 days of relocation or as clinically indicated.

   e. Receiving course of antibiotics: every 8 hours at a minimum for the entire course of the antibiotics.

   g. Unanticipated change in resident condition or potential/actual decline: check V/S once per shift at a minimum for 3 days as often as clinically indicated depending on the nature of the change.

   g. Fall incident: check V/S once per shift at a minimum for 3 days or as and as clinically indicated.

   g. New wounds or worsening of skin ulcers/wounds - check V/S once per shift at a minimum for 3 days and as clinically indicated.

C. Reporting

1. CNA or PCA should report immediately to the licensed nurse in charge of the resident if:
   a. BP is less than 90/50 or greater than 160/90
   b. PR less than 50 or greater than 100
   c. RR less than 14 or greater than 25
   d. T over 100 degrees F
   e. O2 sat of less than 90
   f. Pain score is greater than 0
   f. Orthostatic V/S changes

2. Licensed Nurse (LN) is to assess resident immediately and notify physician as needed further medical evaluation.
D. Documentation:

1. Record vital signs V/S (BP, PR, RR, T, & O2 sat) and pain level in medical record.

2. A licensed nurse LN reviews the V/S. After a licensed nurse LN reviews the vital signs, if stable and within baseline, the CNA, or PCA, or the unit clerk may chart them on the electronic documentation system. In the event of power failure or computer downtime, documentation may be done on the graphic sheet of resident’s medical record. All manually entered V/S should be transferred to the electronic system as soon as the power is restored or once the computer is working.

3. The CNA or PCA can record pain score as verbalized by the resident or as observed using the Pain Assessment in Advanced Dementia Scale (PAINAD) on the electronic documentation system. The CNA or PCA informs the licensed nurse for further pain assessment.

ATTACHMENT 1: Automated Vital Signs Machine Operating Guidelines

ATTACHMENT 2: Quick Reference Guide for Electronic Documentation

REFERENCES:

Sorrentino, Mosby’s Nursing Assistants, 6th edition, 2004

CROSS REFERENCES:

LHH Policies and Procedures: 25-06 Pain Assessment and Management
Nursing Policies and Procedures: C 1.0 Admission and Readmission Procedures
Nursing Policies and Procedures: C 1.2 Relocation Procedure
Nursing Policies and Procedures: C 1.3 Discharge Procedure
Nursing Policies and Procedures: G 2.0 Neurological Status Assessment
Nursing Policies and Procedures: C 3.0 Documentation of Resident Care by Licensed Nurse
Nursing Policies and Procedures: C 3.2 Documentation of Resident Care by Certified Nursing Assistant and Patient Care Assistant
Nursing Policies and Procedures: J 1.0 Medication Administration

Reviewed: __________11/10/201507/31/2012
Approved: __________07/31/2012
Protocol for Resident Escort Off Hospital Grounds

PURPOSE:

1. To maintain resident safety while escorting the resident and provide guidance to nursing staff in obtaining and communicating relevant information regarding clinic appointments off LH grounds.

2. To maintain thorough and confidential documentation that preserves the resident’s privacy.

A. General Guidelines

1. Nursing staff shall be assigned to escort the resident to and from off-campus clinic appointments as necessary.

2. The resident is not to be left unattended without clinical personnel.

*Note: In the event of an urgent situation when escort has to leave temporarily, it is the escort’s responsibility to endorse and receive verbal agreement with clinic staff for supervision of resident until escort return (e.g. need for restroom, food, water, etc.).

3. The escorts are expected to take care of their personal needs first prior to leaving Laguna Honda Hospital grounds (i.e., need for restroom, food, water, etc.).

4. In the event of that the resident and escort missed the scheduled transportation pick-up or the resident is admitted to the acute hospital, the escort must call the unit as well as the Nursing Office for further instructions. Refer to LHHPP 24-08 Off Campus Appointments or Activities.

B. Responsibilities of the Escort

1. The escort’s sole responsibility is the resident’s safety and well-being.

2. Comply with confidentiality rules. The escort is not to handle any medical records except for “Instructions to Escort Form” which is not to be stamped with addressograph information.

3. The escorts sign-in at the Nursing Office and receive their assignment.

4. Report to the neighborhood to receive pertinent information regarding the resident’s appointment.

5. Escorts are responsible for obtaining all the necessary information from the charge nurse or unit clerk, including the unit telephone number. Escorts shall be instructed to first call the unit in the event of a problem.

6. Escorts must introduce themselves to the resident and give a brief explanation to the resident about what to expect in effort to reduce possible anxiety and build rapport.

C. Preparing for the Appointment

1. The unit clerk or charge nurse shall provide the escort with the resident’s gold card and any pertinent information which must be written on the Instructions to Escort Form (Refer to Attachment 1) including:
Protocol for Resident

Escort Off Hospital Grounds

a. Any Risks such as behavioral challenges, elopement, etc.
b. Neighborhood Phone Number
c. Destination (including phone numbers)
d. Time of Appointment
e. Reason for Appointment
f. Van Service Name (including phone numbers)

*Note:* If resident has never been to SFGH and no gold card was given, the escort must first accompany the resident to SFGH Admission Department to register and obtain a gold card.

2. Escorts shall be instructed by the Charge Nurse or designee where and when the resident’s appointment is to take place (i.e. specifically what radiology test, not just report to radiology).

D. During the Appointment

1. The escort should assert their responsibility for safety of the resident and never leave the resident for any reason, even at the resident’s request.

2. The escort is responsible for accompanying the resident into the exam room even in the presence of family member or loved ones, unless the resident is their own decision maker and requests escort not be in the exam room.

3. The escort shall call the neighborhood team for further instructions in the event of any problems (i.e. resident elopement, or appointment runs late, etc.).

E. After the Appointment

1. The resident and escort will meet the transport service at an agreed upon designated location and return to LHH.

2. The escort is responsible for accompanying the resident to their neighborhood and reporting off to nursing staff upon return.

3. The escort will provide the neighborhood charge nurse with the follow-up contact number for further instructions and follow up.

4. The Escort shall report to Nursing Office to report the time of their return.

ATTACHMENT:

Attachment 1: Instruction to Escort Form

CROSS-REFERENCES:

LHHPP File: 24-08 Escorting Residents To Off Campus Appointments or Activity

New: 09/11/2015
Reviewed:
Approved:
INSTRUCTIONS TO ESCORT
(To be completed by escort)

Resident (Last Name only)______________________________________________

Go to unit Charge Nurse to get hand off report:
A. Precautions:

□ Falls Risk  □ Aspiration Risk  □ Elopement Risk
□ Behavior Risk

□ ____________  □ ____________

B. Special Instructions:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

DO NOT ADDRESSOGRAPH THIS FORM
1.27 Sign in Sheets

Established and Revised: 1/86, 1/89, 5/97, 9/06, 5/08, 7/09, 6/11, 8/14
Reviewed: 8/13, 8/14, 8/15

Policy:
Nutrition Services will maintain and process employee payroll time sheets on a weekly basis. There will be a weekly computer printed sign in sheet that each employee will be responsible for signing in/out each day of work.

Purpose: To record the payroll time of each employee in the department.

Procedure:
Week-to-date Payroll sheets for Nutrition Services Department will be maintained in three designated binders for Production, AM Tray Service and PM Tray Service, along with on-call/as needed. The original set of the weekly payroll sheets will be maintained on the table directly across from the elevator in the designated binders. “Back up” copies of the time sheets will be maintained in the Chef’s Office.

Each Member of the Staff will sign their name once a week on their scheduled first work day of the week. During the rest of their scheduled work week, they will record in and out time worked. ie: sign in: 7:00 AM; sign out: 3:30 PM. They will initial their 30 minutes meal break.

If a staff is scheduled to work a split shift, ie: a part time staff is scheduled to work the breakfast meal service then returns later in the late afternoon to work their normal assigned shift for the dinner meal service, they are to sign in both times on their designated slot on the time sheet. ie: sign in: 7:30 am and sign out: 10:30 am, then later, sign in 5:00 PM and sign out: 9:00 PM and they initial their 30 minutes meal break.

If there is room in the section, the Supervisors and/or Chefs will note in the comment section if a staff was reassigned to either AM Tray, PM Tray or Production; or if the staff worked extra hours or overtime.

Each day just prior to exiting the Department and the end of their shifts, the PM Supervisor / Team Leader will make one copy of the week-to-date payroll sheets. They will insert the “back up” copies of the payroll sheets into a designated binder for that week located in the Chef’s Office. Copies of the “back up” payroll sheets will be maintained on file in the Chef’s office for one day, after which the PM Supervisor / Team Leader will dispose of the older copy of the “back up” payroll sheets. If for any reason, the original week-to-date payroll sheet is lost, a copy of the “back up” payroll sheets will be made by the AM Chef and put into the designated binders then to be used as original.

The PM Supervisor / Team Leader will place the three designated binders into the Chef’s Office at the end of the day. The AM Chef will place the three designated binders on the designated table across from the elevator each morning.
Each day, the AM Chef, AM Supervisor, and PM Supervisor will go through the time sheets to record the staff’s time worked or off time and approve time from the day before by initialing at the bottom of each column. Follow the posted legend for codes ie: V, SK, FH, LD, OU, H, etc.

The above described tasks of copying and filing “back up” copies of the week-to-date payroll sheets do not alter, change or modify the Diet Clerk’s responsibility of processing and copying the original weekly payroll sheets, obtaining authorized signatures and transporting to the Payroll Department in a timely manner. This will be accomplished once a week at the designated deadline from Payroll. Copies of the weekly payroll sheets will be kept on file for one year in the Diet Office.

The Food Service Manager and/or Assistant Food Service Director will review and approve the payroll sheets prior to processing them through the Payroll Department.

If there are any discrepancies with the payroll sheets, the employee’s immediate supervisor will discuss it with the payroll clerk responsible for Nutrition Services.

Each week, the Diet Clerk will exchange with new copies of the payroll sheets. 1.  When an employee comes into work on the first day of the employee start week, he must sign his name at the individualized line provided. Throughout the week, he must record the exact time at which he arrives to work. If the employee was scheduled to start at 7:00 AM but comes in at 7:05 AM, he must indicate it so. These sign in sheets are in a binder located in the following locations:

**Employees Work Location Sign-in Sheet Location**

Production Kitchen Kitchen

Tray Service Trayline Kitchen

Chefs Kitchen Chef’s Office

Supervisors Kitchen Chef’s Office

Dietitians Neighborhood/B400 Dietitian’s Office

Managers Office Dietitian’s Office

Director Office Administration

If the employee's name does not appear on the sign-in sheet, he/she is to notify the shift supervisor to write his/her name in.

All signatures should be in blue or black ink pen.

2.  When an employee's day is over, he must sign out at the exact time he is leaving work. The employee will initial the area provided for meal break taken. Note: the employee shall not sign out at the same time he/she signs in.

3.  The shift supervisor will record the number of hours work for all employees scheduled for that day and mark those that were absent for one reason or another. When marking the absent employee, he must use the codes listed at the back legend page of the binder. If the employee is late, please dock his/her hours.
accordingly and write in the statement box, Tardy. Any employees that worked “Overtime (OT)” or Compensatory Time Earned (OE)” must be approved by Management.

After daily review, the supervisor will initial at the bottom.

4. At the end of the week, the Chef and/or Supervisor will total the number of hours the employee worked or approved time off. The Chef and/or Supervisor will sign and date at the bottom line of the time sheet.

5. The Food Service Manager and/or Assistant Food Service Director will review and approve the time sheets.

6. The time sheet will be Xeroxed and kept in the department’s files and the original copy will be forward to the Payroll Department for processing.

7. If there are any discrepancies with the payroll sheets, the employee’s immediate supervisor will discuss it with the payroll clerk responsible for Nutrition Services.

***Note: Employees are required to work a full shift. The San Francisco Charter states in Section 8.400(g): “At no time, no officer or employee shall be paid for greater time than that covered by his actual services.”
1.28 Work Rules for Nutrition Services Department

Established and Revised: 2/81, 5/84, 12/87, 1/89, 5/97, 9/06, 7/09, 6/11, 8/15, 9/15
Reviewed: 8/13, 8/14, 8/15, 9/15

Policy: The following rules are essential for the safe and efficient operation of the Nutrition Services Department. This is not meant to be comprehensive, normal rules of courtesy, consideration, respectful and good taste does apply. It is the obligation of the employee to become familiar with these regulations and to comply with them accordingly. Any employee who fails to maintain proper standards of conduct or who violates these rules subjects himself/herself to formal corrective disciplinary actions, ranging from warnings to dismissal.

Purpose: To assure proper operations of the department through understandable and uniformly applied rules and regulations.

Procedure:

1. Use of the telephone only emergency calls will be put through to employees during work hours. Employees should use public telephones for personal business. Cell phone use is limited to break times and emergency calls. The employee must inform their supervisor and step away from the Production and/or Meal Service area.

2. Employee lockers are available. You will only be allowed to occupy one locker. There are lockers located near the Chef’s office, 2nd floor near Material Management in the old building and the loading dock. The condition of the locker shall be responsibility of the persons using it.

3. Restricted Areas, Certain area of the hospital is restricted. It is requested that unauthorized employees remain out of these areas that are solely intended for residents or other hospital staff, unless you are performing your assigned duties in the area.

4. Solicitation or distribution of materials during work hours is prohibited without the express consent of the Assistant Administrator of Nutrition Services, Food Service Director.

5. Packages: All packages carried into or out of the hospital are subject to inspection by Management or Sheriff’s Department.

6. Address Changes: Employees are required to notify the department of any change in address, telephone, name or other pertinent personnel information. For payroll purposes, they are to notify Human Resources Department of any changes as listed above.

7. Visitors are not allowed in the work areas of the department.

8. No children may be brought to work unless on special days that is permitted by the Hospital such as “Bring your child to work day.”

9. All employees shall be ready for work at time of sign in.

10. All employees that have jobs that require it, employees shall be given 10 minutes at the end of the shift for personal clean up time.

11. All employees are directly responsible to their supervisors and should always follow a direct instruction, failure to do so will result in formal disciplinary action.

12. Employees are to report to work in clean clothing and bathed using societal guidelines for personal sanitation. This includes following the standard dress code within this department.
13. Always lift objects using proper lifting technique, use your legs not your back!
14. The best method for Infection Control is to wash your hands frequently. Always wash hands prior to your shift, resuming work, before and after breaks, before and after handling food, in-between tasks, handling refuse, or using the restroom. Wash sinks are available in the restrooms, the chemical storage room, outside of the potroom, and out in the cafeteria.
15. Change task = Change gloves (wash hands in-between)
16. All employees must refrain from wearing and using hearing devices (ie: Bluetooth, earphones, headphones, ear buds, etc) while on duty in the production kitchen, galley and/or cafeteria service. This is for the safety of the employee so that they can better concentrate and listen for hazards while working in their environment.
17. We observe the "No Smoking" ordinance hospital wide. Smoking is not allowed while on duty.
18. Chewing of gum, chewing of matchsticks, and chewing tobacco, furthermore, are not permitted, for sanitary reasons.
19. Use of drugs or alcohol while on duty is strictly prohibited, as is, reporting to work under the influence of these substances.
20. Eating or drinking on duty is limited to testing food quality. Meals and other items may be consumed at breaks and lunch period in the employee cafeteria. Food from the Galley Service should not be consumed; these are for resident use only.
21. Never cough or sneeze into your hands. Use a handkerchief, then wash your hands immediately.
22. Report all accidents or dangerous conditions you may observe.
23. Horseplay, practical jokes, fighting or other forms of personal confrontation are not allowed.
24. There will be no gambling on hospital's premises. Disciplinary actions may result from such activities.
25. Always be courteous to fellow employees, supervisors, managers, residents and other hospital staff and guests.
26. It is very important that the rights of the residents are always be maintained, never touch a resident, always be courteous to residents, notify the nearest medical personnel or your supervisor in the event you suspect a resident may be having a problem or is abused. Never offer to “give a light” to a resident.
27. Firearms, whether real or replicas (toys), are not permitted within the hospital. Disciplinary actions will result along with an investigation from hospital security.
28. When in doubt about any situation, ask your supervisor.
29. Follow all the policies and procedures of the department and hospital.
30. Use common sense when completing a task and perform all tasks in a safe manner.
1.3 Disaster Plan

Established and Revised: 2/81, 5/84, 12/87, 1/89, 5/97, 5/00, 4/06, 5/08, 7/09, 10/10, 6/11, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: All units designated to respond to community emergencies will have specific guidelines and a plan of action for disasters.

Purpose:
- To allow advance planning for possible emergencies.
- To provide directions to personnel in emergencies so that the operations in the Nutrition Services Department can continue.
- To provide food and water to residents, staff and visitors and to participate in a community response to a disaster.

Procedure:
Laguna Honda Hospital has a Disaster Plan Manual that sets out the policies and procedures for responding to emergencies. The Nutrition Services Department has developed a unit specific manual to guide personnel during a disaster. See Appendix 2: Link to Disaster and Emergency P & P.

A telephone tree of management and clinical employee numbers is distributed to provide callback numbers in emergencies. The line staff telephone numbers are in the files of the Food Service Manager, all supervisors and Chefs.

Employees are called to work as necessary and may contact the department by Voice mail to 415-682-5776 or 682-5778 or another designated number.

Internally, the call back roster will be initiated at the direction of the Director of Nutrition Services.

After employees are evacuated from dangerous areas. Personnel on duty will begin an immediate triage of the department to identify any injuries and damage that may create a hazardous work area.

Report all serious or life-threatening injuries immediately to the Command Center (4-4636, remember 4-INFO). Stay with the employee or resident until assistance arrives.

Be aware of Safety around damaged equipment or falling debris. Remove what can be cleared safely to allow for clear pathways through the Food Service area.

The first available employee will report to the Command Center in B102 to communicate any injuries and the condition of department.

Department personnel will survey the department to identify which utilities are available (water, gas, electricity, telephones) and to assess any damage. Alert the Command Center immediately if
water, gas, or electricity is leaking, sparking or otherwise damaged, causing a hazard to employees. Remove all personnel and residents from these areas, away from windows or light fixtures. Please do not attempt to repair any damage.

**Note: In some cases, all utilities may be turned off at the main valve.

If required to resume operations, request assistance from the Command Center to help clear debris and open blocked doorways and stairwells. (If the on-site supervisor orders evacuation, cautiously move obstructions along the evacuation route. Stay together and know where the evacuation site is before you leave the department). **Do not use elevators.**

If operations can continue, employees will work together to complete an inventory of food and supplies currently on hand in the department. All food resources will be included in the inventory, including enteral and supplemental formulas. Based on a seven day emergency menu, to meet the meet the minimum requirements for 2,000 people (residents, staff, visitors, triaged from community), we have seven days of established staple food and three days of perishable on hand in inventory. (Note: The staple food items will be rotated every six months within our regular menu cycle.)

Identify any food stores that have been damaged and dispose of them, as directed by the Command Center. Do not remove or issue food for preparation or service until it has been inspected for damage. Do not drink tap water until advised of its safety. Use bottled or boiled water.

The Director of Nutrition Services will activate the seven day emergency menu as developed by the Chief Dietitian. The menus will include certain therapeutic and texture modifications diets.

We will assess the damages to equipment and respond accordingly. We will continue to utilize existing pots and pans for the cooking process. We will utilize existing serving utensils as required to serve the food. We will utilize the dish-machines and pot-machine for the ware-washing process if they are functional after the initial assessment of equipment. If they are not functional, we will wash by hand using the proper dilution of chemical and rinse with a bleach-based sanitizer either in the pot-room sink and/or steam jacket kettle. The hospital houses 600,000 gallons of water for emergency use. Some of this portable water will be used in the cooking and ware-washing process. In addition, there is an inventory par of 60 cases of half liter bottled water that can be utilized as required. We may utilize the usage of disposable products such as pans, plates, cups and flatware, as needed.

Deliveries of meals and nourishments will be placed on hold until the Command Center approves movement through the facility. Contact the Center to determine how meals will be transported to residents, employees, and visitors.

Emergency food supplies will be provided through primary food vendor on a priority basis. Novation agreements supply back up food resources if the primary vendor is not available.

Refer to Appendix 2: Link to Disaster and Emergency P & P.
1.6 Menu Development Process

Established and Revised: 2/00, 9/06, 7/09, 7/13, 8/15
Reviewed: 8/13, 8/15

Menu Meeting - during this meeting, a collective group such as the director, chief dietitian, assistant food service director, food service manager, chef, supervisor and diet office coordinator, exchange ideas that are generated and action plans are developed. This is not development of a menu or recipe itself. Coordination of plate presentation, production standards and restrictions, purchasing guidelines, dietary restrictions are all discussed here. The development is done prior to or subsequent to this meeting. This is the most important meeting which we all participate because the menu defines what we are.

Dietitian's Meeting - all significant menu changes are discussed with the R.D.'s. We try to achieve consensus so the person actually at bed or table side is in fact buying into the new menu or recipe. The dietitian has three main concerns: 1) patient acceptability and/or tolerance of the item, 2) clinical, 3) hospital staff issues (e.g. relating to feeding, etc.).

Weekly Staff Meeting - menu items are discussed and direction is enhanced.

Recipe Development & Testing - Recipes are developed through the CBORD system. Chefs and cooks will work together to help develop and test the recipe. During the process the recipe is taste tested, weighed, scaled, checked for color, and nutritionally analyzed. All recipes will have the final approval by the Chief Dietitian. What we think will work is not always what will work, especially for large quantities. Cooks must understand the recipe. During the process the recipe is taste tested, weighed, scaled, checked for color, and nutritionally analyzed.

Purchasing - We essentially purchase product from approved vendors 10 to 17 days in advance, meaning new menu items must entered into CBORD with this lead time at least with this lead time. We do have flexibility to change this process as needed and it will depend on product availability through the vendor. We do have flexibility to change this process; however, a major menu change without this lead purchase time would be shaky.

City Purchasing or Vendor Issues - they may need to be involved, which may increase the time necessary to purchase and order products for the menu. Often they need to be involved which can really increase the time necessary.

Note: All menus are coordinated for color, taste, consistency, nutritional adequacy, appeal, and presentation, while keeping in mind the position in the cycle. The menu development process is a complex one for this institution and cannot be accomplished overnight.

The Chief Dietitian will approve all menus prior to posting.
1.7 Weekly Menus

Established and Revised: 3/81, 3/84, 3/85, 1/89, 5/97, 2/04, 9/06, 7/09, 7/13, 8/15
Reviewed: 8/13, 8/15

Policy: Two weeks of menus are distributed to hospital wards.

Purpose: To provide communication to resident and employees of the menu planned for each day for a period of two weeks.

Procedure:
Menus, as approved by the Chief Dietitian, available for viewing on each Neighborhood will consist of a two (2) week package consisting of the current weeks menu and the week after the current weeks menu, which includes substitutions. Standard Substitutes are listed in the back of each day’s menu.

In addition to the English language, menus will be written in Chinese, Spanish, and Tagalog.

- Diet Office Coordinator

The Diet Office coordinator (or relief) will update Resident menu for all menu line items changes within 48 hr of approved changes (by Chief Clinical Dietitian or relief). 2- Diet Office Coordinator will progressively revise dates on menus in the computer for accuracy prior to distribution to Neighborhoods by Diet Clerk

- Diet Clerk

The late Diet Clerk (or relief) will send approved and revised menus correctly dated to CCSF Distribution department at least two weeks in advance of Neighborhood posting date 2- Upon of return to LHH Nutritional Services Department the Diet Clerk delivers menus to LHH Mail room on Thursday (not later than Friday) of each week for distribution to the LHH Resident Neighborhoods by Monday morning.

The menus for the five major diets are listed. Portion sizes are printed next to all the menu items.

CBORD reports are printed on a daily basis.

Menu Substitutes are prepared for each meal. These menu substitutions are made on the Service Summary Report in the Kitchen of the Nutrition Services Department after it has been approved by Chief Dietitian or appointee.
1.71 Replenishing Juice and Coffee Dispensers in the Neighborhood Great Room

Established and Revised: 12/10, 7/12, 8/14, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: To ensure that residents and staff have access to juice and coffee at all times, a Food Service Worker will replenish the juice and coffee dispensers located in each Neighborhood. In addition, the dispensers will be cleaned and sanitized once a day.

Procedure:

1. Each morning, two food service workers are assigned to replenish the coffee and juice in each of the thirteen neighborhoods. One will complete the North Building and the other will complete the South Building and Pavilion Building. The Food Service Worker will fill out a check form and return the form to the Supervisor.

2. The Food Service Worker will gather the necessary containers of bulk juices from the refrigerator (Apple and Orange), quart size cranberry juice and packages of coffee (regular and decafe) from the storeroom. (Apple, Cranberry, Orange and Ice Tea) and packages of coffee (regular and decafe) from the storeroom. The Food Service Worker will gather the necessary cleaning supplies using the three bucket method.

3. Before replenishing the dispensers, the Food Service Worker will use the three bucket method to wash, rinse and sanitize the outside and interior of both dispensers. They will empty the catcher on the juice machine into a large bucket and dispose through the Salvajor unit in the Galley or main dishroom.

3.4. The Food Service Worker will restock the Galley Refrigerator up to the designated par of quart size cranberry juice. They will look at the date of any opened container of cranberry juice and dispose of the product if it’s been more than three days (72 hours). They will date any container of opened cranberry juice if there is no date.

4.5. The Food Service Worker will replenish with new product as needed. The Food Service Worker will date each juice and ice tea product that they replenish.

5.6. The Food Service Worker will report any concerns or problems with the product or dispenser units to the Food Service Supervisor. The supervisor will take the necessary corrective action in reporting conditions to either the coffee or juice manufacturer or Facility Services.

6.7. On a monthly basis, the juice vendor will complete a check on all juice dispensers. The service will be noted on each machine.

7.8. On a monthly basis, the coffee vendor will complete a check on all coffee dispensers. The service will be noted on each machine.
1.77 Fire and Fire Drills

Established and Revised: 4/81, 1/89, 1/93, 5/97, 9/06, 7/09, 8/14, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: A Fire Plan will be posted in designated areas in the Department. In addition, fire plan is attached on a separate card on all employees’ hospital identification card. This plan will include Fire Alarm Station Locations, Emergency Exit Doors, and Fire Drill Procedures. All employees will participate in Fire Drills and Emergency Preparedness Inservices which includes Fire Prevention and Safety.

Purpose: To protect employees from fire hazards.

Procedure:

When a fire occurs:
1) Upon notification of fire, department personnel immediately should take the following actions.
2) Use the acronym: RACE: Rescue  Alarm  Confine/Control  Evacuate /Extinguish
3) Personnel should move out of immediate danger of the fire while announcing CODE RED to nearby staff and residents.
4) Dial 9-911 and report the emergency, report that this is Laguna Honda Hospital, the exact location and building number.
5) Sound the alarm by pulling the level on the nearest alarm box.
6) Dial 42999 to alert the operator of Code Red, providing with the following information: *Location of the fire  *State what is burning  *Your name
7) Close all windows and doors, where appropriate.
8) Shut off all equipment in the general fire area for electrical and gas.
9) Use the acronym: PASS = Pull pin;  Aim;  Squeeze lever and Sweep side to side
   a) Control all small fire whenever possible with the appropriate fire extinguishers. For grill fires, pull lever for overhead fire extinguisher, standing back in the process to avoid any unnecessary intake of CO2.
10) Initiate local evacuation if necessary. This procedure should be initiated by the fire department, institutional police or safety engineer.
11) Escape Routes for staff working in the kitchen:
   a) Main Kitchen will exit the back door onto the back loading dock area – push on glass doors if they don't open automatically. Check in with Supervisor and wait for further instructions
   b) Trayline Area – exit through double doors, turn left and go down the corridor and turn left after the restrooms and offices and go out through the door to the back loading dock area. Check in with Supervisor and wait for further instructions and go toward old building and down the stairs to outside Administration Offices and wait by the flag pole.
   c) Dishroom Area – exit through double doors, turn left and go down the corridor, turn left and go pass trayline doors, then turn left after the restrooms and offices and go out through the door to the back loading dock area. Check in with Supervisor and wait for further instructions and head for stairwells located in South 2.
   d) Cafeteria – exit through the dining room towards old building; exit through double doors and wait by flag pole. Check in with administrative staff and wait for further instructions.
1.9 Menu - Special Events

Established and Revised: 3/81, 3/84, 3/85, 1/89, 5/97, 7/09, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: We will review our current menu and make appropriate changes in menu items to reflect honored special calendar/cultural events.

Purpose: To provide variety to the menu by offering special menu item that may reflect honored special calendar/cultural events.

Procedure:
The Chief Dietitian will approve the calendar of special holidays that we wish to commemorate each year. Director of Food Services provides a calendar of sample events as listed below:

<table>
<thead>
<tr>
<th>Event</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Day</td>
<td>July</td>
</tr>
<tr>
<td>Halloween</td>
<td>October</td>
</tr>
<tr>
<td>Thanksgiving Lunch</td>
<td>November</td>
</tr>
<tr>
<td>Christmas Lunch</td>
<td>December</td>
</tr>
<tr>
<td>Martin Luther King, Jr. Celebration</td>
<td>January</td>
</tr>
<tr>
<td>Chinese New Year Special</td>
<td>February</td>
</tr>
<tr>
<td>St. Patrick's Day</td>
<td>March</td>
</tr>
<tr>
<td>Cinco de Mayo Special</td>
<td>May</td>
</tr>
<tr>
<td>Filipino Independence Day</td>
<td>June</td>
</tr>
</tbody>
</table>

Other events may be planned accordingly. Nutrition Services Department will schedule the special menus and coordinate the special event in conjunction with Activity Therapy Department.

Other Special Events:
- Monthly Neighborhood Birthday Party; Mother’s Day; Father’s Day; Easter; President’s Day; Valentine’s Day; Memorial Day; Labor Day.
- Monthly Ward Birthday Party; Valentine’s Dinner Dance; St. Patrick’s Day Irish Party

The menu committee will write special event menus. The Chef Dietitian will review menus for special diet modifications.

The special event menu will replace the current cycle menu.

The special event menus will be scheduled on or before the holiday celebration.

If a menu is not changed, we will add special colored napkin along with flyers indicating the special event.
1.104 Blast Chiller Operational Procedure

Established and revised: 3/05, 9/06, 7/09, 9/15
Reviewed: 8/13, 8/14, 9/15

BLAST CHILLER OPERATIONAL PROCEDURE

HACCP STANDARDS – COOLING, HOLDING AND REHEATING OF FOOD

To maximize nutrient retention of foods after preparation and cooking all hot foods will be held at the designated serving temperature (165* - 190*) for a maximum of forty-five (45) minutes. All hot foods that have been cooked or heated above 40* that will not be served within forty-five minutes will be cooled rapidly in a 2” (inch) deep metal insert inside the blast chiller until the internal temperature is 40* or less. To cool large cuts of meat each piece of meat will be cut into ten (10) five (5) pound pieces, then cooled in the blast chiller. The temperature of all foods cooked or heated above 40* must be lowered to an internal temperature of 40* or lower with in four (4) hours.

The PM Cook will coordinate with the AM Cook as to when the meats will be removed from the Baxter or slow cooked ovens and place into the blast chiller. The cook will ensure that the probe (s) be inserted into the meat (or product) that is going into the blast chiller. The cook will start the blast chilling process per manufacturer’s operating guide posted on the Blast Chiller. The cook will ID contents of blast chiller. The Chef is accountable to replace Blast chiller tape if out. When Blast chiller is in use, tape must be printed at the end of the cooling process and must be attached to the cover of the product in the refrigerator. When smaller quantities of meat and poultry (under 50 #) are cooked and chilled, properly store this meat in the # 6 walk-in on the designated shelves and date, label, and cover it.

Other staff who uses the Blast Chiller to cool down other food items (ie: custard) other than meats, should follow the same procedure as described.

The Chef – Production will take the Blast chiller tape, review the outcome to ensure that it meets standards for cooling down the product, label the tape and document it in the Cool Down Log Binder located in the Chef’s Office. Management will review the Cool Down Log Sheets on a monthly basis.

The re-heating of food by means of steam (or other methods) shall commence not more than one and one half (1 ½) hours prior to the start of meal service. The recipe will be followed for specific instructions. The reheating of food by steam (or other methods) will not commence until:

5:30am – breakfast

9:45am – lunch

3:45pm – dinner
All foods will be reheated to a minimum internal temperature of 165° commencing not more than one and one half-hours prior to meal service.

The Section Cook (Team Leader) is the primary Production worker responsible of maintaining this policy under the direction of the Duty Chef.

Cafeteria Service
1.115 Cafeteria Cash Sales Record and Handling and Recording Procedure

Established and Revised: 2/81, 5/84, 12/87, 1/89, 5/97, 03/04, 9/06, 7/09, 8/11, 2/13, 3/13, 8/14, 8/15, 9/15
Reviewed: 8/13, 8/14, 8/15

Purpose: To prepare and document financial reports.

Procedure:

All Nutrition Service Mgr's/Sup's/Cashiers
LHH Cashier/LHH Accounting Volunteers/Pastoral Care/Students

The responsibility for verifying daily cash register tapes with actual cash receipts and accounting for discrepancies is that of the Chef-Administration. The Chef-Administration is accountable for providing change to authorized departmental cashiers from the cafeteria change bank (located in the Chef's office). The procedure for cash control is as follows:

1. The Morning Chef will provide the two (2) A.M. Cashiers $150.00 float fund consisting of ones, fives, and change (suggest 40 - $1.00's, 17 - $5.00's, and $25.00 in change). Upon receiving the two (2) $150.00 floats, the cashiers are to count them and alert the Chef-Administration if there are any discrepancies. The AM Cashiers will log into their registers and insert the cash and coins.

2. The Production Clerk will properly head the Daily Sales Report Form each day. All purchases are to be paid for with cash or credit card (except L.H.H. students and Residents with valid meal cards who are exempt from this policy). Cashiers will ring up meal card transactions under appropriate category; ie: Students.

3. Before 9:00 A.M. five days a week, the Production Clerk will take the previous day’s cafeteria cash, the original cash register tapes and the completed deposit slip to the Laguna Honda Hospital cashier for deposit. The completed deposit slip and the cash register tapes along with its original will be signed by the hospital's cashier and the Production Clerk after the cashier counts and verifies the deposit total. The Production Clerk will return one copy of the deposit slip and one copy of the cash register tapes to the Cafeteria Daily Sales Report binder and attach it to the day’s sales report.

4. Any necessary change will be bought with the cafeteria change bank ($63.00 bank in a strong box stored in the safe.) A standard par of eight (3) rolls of quarters, four(4) rolls of dimes, four (4) rolls of nickels and ten (10) rolls of pennies shall be maintained. Nutrition Services total cash' accountability: Bank-$63.00, Reg #1 Float-$150.00, Reg #2 Float- $150.00 Grand Total- $363.00.

5. (IF DINNER MEAL SERVICES IS PROVIDED….. CURRENTLY NOT PROVIDED) Monday through Friday the Chef-Administration will provide the P.M. cashier with the $150.00 float fund consisting of ones, fives, and change (suggest 40 - $1.00's, 17 -$5.00's, and $25.00 in change). Upon receiving the $150.00 float fund, the P.M. Cashier is to count it, and alert the Chef-Administration if there are any discrepancies. The P.M. Cashier will log into the register and insert the cash and coins.
6. When change is required by the cafeteria cashiers, a chef on duty or production clerk must be contacted to open the safe. Change will be made from the cafeteria change bank kept in the safe. Should additional change be required, a supervisor or the production clerk will secure it from the hospital cashier. All cash (change bank and register float funds) is to be secured inside the locked safe inside the Chef’s office during non-business hours.

Note: Effective July 1, 2013 - Whenever the safe is open two (2) individuals must be present as witnessed by signatures below per order of CCSF Office of the Controller. The Chef Administration is accountable for managing this procedure and insuring the log is presented to ADNS for review each month. This log is to be maintained on a clip board on or near the safe, then, filed in a binder on the book shelf in the Chefs office entitled “Safe Access Log”

7. All over ring receipts will be initialed and dated on the back by the cashier with an explanation ie: "customer forgot wallet". A brief explanation and cashier's initials are required on the back side of the receipt. Over Ring receipt will then be deposited into the cashier drawer to be reconciled by the chef on duty or production clerk at end of the shift. These over ring receipts will be filed in the Daily Sales Report folder. Should a discrepancy exists that exceeds $5.00 of the sales the Chef-Administration will start an immediate investigation and record all finds in the Daily Sales Analysis Binder.

8. At the close of business each cashier will count the total cash and change in the register drawer and record their totals onto the Cafeteria Cash Work Sheet. The Cashier will attach all credit card receipts to the Cafeteria Cash Work Sheet. Credit Card sales are totaled by the cash register and recorded on the tape. The Production clerk will recount and verify accuracy of the Cashiers Work Sheet, then sign and date each Work Sheet. Cashiers then count out the $150.00 floaters and return it to the box #1 or Box #2.

9. Cafeteria readings from both registers will be taken, verified and recorded on the Daily Sales Analysis Report at 2:00 PM by the Production Clerk. Should a variance exist between the cash register tape readings and actual cash total the Production Clerk will note directly on the deposit slip in black ink the actual cash count total. The Production Clerk will sign and date the deposit slip. The Production Clerk will immediately inform the Chef-Administration if any discrepancies greater than $5.00 exist between the cash and the register readings after 2:00 PM. Should a discrepancy exists the Chef-Administration will start and immediate investigation and document all findings.

10. After settling both registers and recording on the Daily Sales Report sheets by the Production Clerk, all cash, credit card receipts and register tapes for the day's transactions along with the money are removed from the cash registers. Float funds will be counted by the cashiers using Cafeteria Float Work Sheets and placed into the respective #1 and #2 metal boxes and given to the Production Clerk and Production Clerk verifies cash count placed in the safe. The Cashier and Clerk will sign & date this Work Sheet.

- A combined daily deposit slip for both registers is filled out and signed by the Production Clerk for that day's transactions. (see deposit slip)
- A photocopy of the deposit slip and cash register tapes are to be made by the Production Clerk and retained in the D.S.R. file cabinet in the Diet Office.
- Deposit slip/tapes/receipts and cash from the day's sales for each register are to be placed in the small metal boxes.
- Both small metal boxes #1 and #2 are to be locked in the safe. On Fridays the cash should be taken to the hospital cashier no later than 3:30 P.M. to secure it for the weekend.
- Upon receiving the deposit, the Laguna Hospital cashier is to count the cash, then date and
sign both the original and a copy of the deposit then give the production clerk one of the deposit slips.

11. The register money (float funds) will be removed from the registers and secured in the safe in the chef’s office along with the change fund. The cash drawer of each register is to remain open after the money is removed.

12. The Daily Sales Report sheet will be filed under Cafeteria Daily Sales Report with the duplicate deposit slip, credit card receipts and LHH cashier's receipt secured to it in the DSA folder.

13. The Production Clerk will document daily on the monthly sales report all cash transactions.

14. The Monthly Sales Report will be given to the Assistant Director of Nutrition Services at the end of the month by the Production Clerk. A copy of the Monthly Sales Report will also be provided to the Hospital Accounting Department for revenue reconciliation by the Production Clerk after review by the Assistant Director.

15. Automated reports from MICROS cash register run every night.  
Credit Card Batch Transfer Status – Shows Previous Settle Count = 0  
Daily Consolidated Revenue Center Sales Detail – Sales for the Day  
Credit Card Batch Detail – Show individual Transaction  
Daily Restaurant Status Report – Show the system is normal:
    Current Business Date = OK  
    Employee Shifts = OK  
    Cashier Shifts = OK  
    Last Database Backup = OK  
    Last Credit Card Batch = It was settled on (date) at (time)

If the Last Credit Card Batch does not match the above you must call CBORD at 607-257-3665, immediately.
1.137 Unusual Occurrence Reports

Established and Revised: 1/87, 1/89, 4/90, 5/97, 9/06, 7/09
Reviewed: 8/13, 8/14

Policy: When an unusual event occurs in the hospital that may have direct effect on residents, staff, or visitors, it is the responsibility of everyone to report it confidentially to the Quality Assurance Committee for further investigation for prevention of reoccurrence.

Purpose: To report any Unusual Occurrences relating to residents, employees, and visitors. For hospital awareness of any unusual occurrences that may occur and make appropriate corrective action.

Procedure:

1. When there is an unusual occurrence that takes place, the involved (directly or indirectly) Management (Managers, Supervisors and Chefs) should file an Quality Assurance Unusual Occurrence Report using the online form. employee should file Quality Assurance Unusual Occurrence Report form. Complete Parts I, II, III, IV of the form and hand deliver it to the locked quality assurance box on 5th floor, across from main nursing office. (See attached copy)

2. Quality Assurance Committee will review and forward onward to the responsible party to investigate and respond to the unusual occurrence. (See attached copy of response form)

3. Any Unusual Occurrences that occur in this department will be followed up with an investigate and respond to the best of our ability to the incident. We should follow up with staff and all individuals that it may apply to. It is reviewed by the Director of Nutrition Services and Associate Administrator of Support Services. All responses should be done in a timely manner and returned to the Quality Assurance Committee.

4. Once there has been a response, the Quality Assurance Committee will review it and make their recommendations.
1.151 Distribution of Payroll Checks

Established and Revised: 2/96, 5/97, 9/2004, 9/06, 7/09, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: Direct Deposit Receipts are available on line. Direct Deposit Receipts for Paychecks and Paychecks will be distributed by the Department.

Procedure:

1. For most employees, paychecks are auto deposit to their specified banks. The deposit receipts will be available on line in which staff may access either on their personal computer or a computer in Human Resources, chef’s office or diet office in the department.

2. If the employee does not have direct deposit, Implementation of pay card program -- Employees who have not elected direct deposit by April 24, 2015 will receive a pay card with their May 5, 2015 paychecks. Departmental payroll representatives will issue the cards, along with a packet of information about the card from U.S. Bank. Beginning on the next payday (May 19) those employees not using direct deposit will receive their pay automatically on the pay card.

3. FAQs and other resources are posted on the City’s ePayroll website.

4. If you have any questions or concerns regarding your paycheck, you must see your supervisor to resolve the issue with the Payroll Department. It is not permissible for you to go directly to the Payroll Department regarding your situation unless directed by your supervisor.

1. Every payday (Tuesdays), the authorized food service personnel will pick up the deposit receipts from the Payroll Department. See Payroll Calendar.

2. The deposit receipts will be available for distribution through the diet office or chef’s office usually after 10:00 AM. (If payday falls after a holiday, it may be later)

3. At the close of the business day, all deposit receipts and paychecks that were not distributed will be kept in the Department’s safe.

4. If you have any questions or concerns regarding your paycheck, you must see your supervisor to resolve the issue with the Payroll Department. It is not permissible for you to go directly to the Payroll Department regarding your situation unless directed by your supervisor.
1.165 Making Deliveries to North Mezzanine Secured Neighborhood

Established and Reviewed: 5/12
Reviewed: 8/13, 8/14

Delivering to NM Secure neighborhood

Procedures for Neighborhoods

➢ Transporting a cart;
  o Departmental hearing device policy is in place while transporting.
  o Ensure all trays are stacked correctly
  o Sign out meal cart on the transporter sign-out delivery sheet.
  o Transport cart through the 2nd floor delivery corridor to North Building elevator at a controlled speed.
  o Watch carefully for residents and ensure that residents always have the right of way at all times.

Procedures for Nutrition Service Staff Entering North Mezzanine

• Staff members who make deliveries will ring the door bell and a nursing staff member who has cleared the area around the door will escort them in.

• 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 anteroom (the corridor between the first and second doors).

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

• After each meal, Nursing staff will lock the doors and wheel the food carts with soiled trays out in the courtyard outside of North Mezzanine will wheel the food carts with soiled trays back into the anteroom for Nutrition Services staff to pick up.

• 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.

• In addition to delivering or retrieving trays, Food Services staff will enter North Mezzanine 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. They can request an escort back to the door as they exit the neighborhood.

• Staff members must be aware of their surroundings at all times and report anything unusual to the Nursing staff or their immediate supervisor.

• Staff members must always ensure that the doors are properly closed when entering and exiting neighborhood.
MEDICAL RECORD Protected Health Information DOCUMENTATION

POLICY:
It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that:

1. Medical records are maintained in paper-based and computer-based formats;
2. A medical record is created for each resident/patient assessed or treated;
3. All medical record entries are legible;
4. The clinical staff are responsible for documentation of the clinical course of the resident/patient;
5. Medical records are legal documents which are the property of LHH and are under the custodianship of the Health Information Services Department (HIS);
6. Medical record documentation is complete and timely to ensure quality of care and continuity of treatment;
7. Medical record documentation includes pertinent facts, findings and observations about an individual's health history, past and present illnesses, exams, tests, treatment and outcomes. It chronologically documents the care provided to the resident/patient and also provides documentation of each resident/patient's medical conditions and treatment for medical, legal and financial purposes;
8. Medical record documentation supports the medical necessity of tests and services for which LHH is seeking reimbursement from government and non-government payors as required by federal and state laws, rules and regulations.

PURPOSE:
The purpose of this policy is to establish guidelines for medical record documentation of healthcare services provided at Laguna Honda Hospital. These guidelines are in accordance with Medical Staff by laws, the Center for Medicare and Medicaid Services (CMS), Title 22 - California Code of Regulations.

SCOPE:
This policy applies to all entities providing healthcare services at LHH.

PROCEDURE:

I INITIATING A MEDICAL RECORD

A A medical record is initiated for all resident/patients assessed or treated. For those resident/patients admitted to the Hospital, this includes the following clinical information:

1) A complete history and physical examination;
2) Initial diagnostic impression;
3) Diagnostic reports (such as consultation, clinical laboratory, electrocardiogram, x-ray and others);
4) Records of medical and/or surgical treatment;
5) Records of pathologic findings;
6) Progress notes; and
7) Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, resident/patient's condition on discharge, and discharge instructions as pertinent.

B Laguna Honda Hospital maintains paper-based and computer-based medical record systems. The hybrid medical record system that utilizes an electronic signature application for transcribed medical reports dictated by the clinical staff. This hybrid medical record system is united by an enterprise-wide resident/patient identification system that is numerical. Clinical and administrative users of these systems recognize that they may have to search paper-based and computer-based systems to find all of the data necessary to perform their duties because all findings and reports associated with resident care are purposely not duplicated in multiple component systems.

C Laguna Honda Hospital supports an electronic signature application for all medical reports dictated by the clinical staff. The acute and SNF dictated medical reports transcribed and signed electronically are: H&P's. Discharge summaries, radiology reports, operative reports, annual assessments, consultations and clinic notes.

D Entries are made in the medical record by individuals having direct primary knowledge of the healthcare services provided to the resident/patient. Such individuals include:
   1) Licensed practitioners,
   2) Other credentialed health professionals,
   3) Physicians in post graduate residency programs, nursing staff and allied health professions students.

II MEDICAL RECORD DOCUMENTATION REQUIRED FOR SERVICES RENDERED

A The following general principles apply to the documentation of each resident/patient treatment encounter by a licensed independent practitioner in order to substantiate the need for the services provided.

1) The resident/patient's medical record clearly, accurately and legibly conveys that:
   (a) the services have been provided;
   (b) the services were appropriate for the resident/patient's condition, and (c) The services meet reasonable standards for medical care.

2) The presenting problem is clear. There is a complete notation of the resident/patient's complaint(s), condition and/or reason(s) for the healthcare visit.

3) Physical exam findings and prior diagnostic test results are recorded. The reasons for ordering diagnostic and other ancillary services should be easily determined, if not specifically described in the record.
4) Assessment, clinical impression or diagnosis is recorded.

5) A plan of care and/or a description of the care rendered during the encounter are documented.

6) The resident/patient's progress, response to changes in treatment, and any revision to the diagnosis is documented.

7) Health risk factors specific to the resident/patient are documented.

8) The date and time, and the legible identifier (Name, signature and title.)

9) Each entry must be able to "stand alone" and support the test, and/or service being reported.

III PHYSICIAN’S ORDERS

A The presence of an order is required to substantiate the medical necessity for laboratory, radiology and other diagnostic services. Orders may be written by a physician or affiliated staff who are working under approved standardized procedures.

B Requisitions for Laboratory tests, Radiology, and other Diagnostic or Therapeutic Services must include:

1) The diagnosis(es) or finding(s) that best define(s) the need for the service(s). This may be the same reason for the hospital admission or clinic visit.

2) The ordering/referring physician's signature, title, and CHN ID number.

IV RESPONSIBILITIES OF THE TEACHING PHYSICIAN

A It must be clearly documented that the attending physician actually provided the services and/or is physically present during the portion of the service.

B Documentation for all minor procedures, surgeries, and interpretation of diagnostic tests must follow the guidelines for documentation of evaluation and management services developed by the American Medical Association.

C It is the responsibility of the attending physician to supervise the practice of medical students and physicians involved in postgraduate residency programs and to approve the diagnostic and treatment regimens developed by them for resident/patients at LHH.

V AUTHENTICATION

A All medical record entries must be timed and dated and signed. Documentation of physicians involved in a postgraduate residency program is authenticated with signature, and title. Documentation of nurses and other health professionals is authenticated with signature and credential designation. All documentation entered by students must be co-signed by the supervising attending physician, nurse, or other health professional.

VI CORRECTING AND AMENDING ENTRIES

A Corrections or amendments by clinical staff

1) Correcting an erroneous entry
(a) The paper record: Any corrections should be made by putting one line through the erroneous entry, writing "error" in the margin and initializing it. Do not erase or otherwise obliterate the erroneous entry; it should remain legible.

2) Late Entries and Addenda: All entries in the record should be written at the time of the event. If it is necessary to make a late entry or addendum to include important clinical information in the record, follow these guidelines:

(a) Label the entry as a late entry or an addendum.

(b) Date and time the entry when it was written (do not back date the entry).

(c) Sign the entry.

(d) Enter the late entry or addendum in the Progress Notes or Nurses' Notes. Do not utilize the flow sheet or graphic records for late entries.

(e) The late entry or addendum should not obliterate any earlier entry.
PATIENT/RESIDENT MEDICAL RECORD

FACSIMILE TRANSMISSION OF PATIENT/RESIDENT HEALTH INFORMATION:

POLICY:

To protect the confidentiality of protected health information (PHI) which is faxed between healthcare providers, within the Department of Public Health (DPH), and within Laguna Honda Hospital (LHH), for the purpose of providing healthcare services in a timely manner. Transmittal and receipt of facsimile (fax) material shall be processed in a timely manner. In general, only non-confidential data will be transmitted by fax unless otherwise specified within this policy.

PURPOSE:

Selected information shall be processed by fax transmission when this procedure is in the best interest of fostering patient care.

PROCEDURE:

The disclosure of protected health information is strictly protected by federal and state regulations. Unauthorized release of medical record information may result in administrative, civil and criminal sanctions, including fines and imprisonment.

I. Routine Fax Transmissions

A. Only City and County personnel employed at LHH preparing to transmit a document must ensure that the document is clearly written and that the patient identification is clearly readable on the document to be faxed.
B. Fax copies will not serve as original medical record copies.
C. Illegible or incomplete documents will be faxed to the sending party for follow-up. Prompt attention to these documents is requested.
D. All fax transmissions must include the current, approved DPH “Protected Health Information Cover Sheet Required for Fax Transmissions, Interoffice Mail, and U.S. Mail & Other Mail.”
E. Fax machines used to either send or receive PHI shall be located in a secure area to which only authorized personnel have access.
F. Faxed PHI should be limited to the minimum necessary amount of PHI to perform the intended task.
PHI should only be faxed to confirmed fax numbers, and shall not be sent to distribution lists. For routine transmission of PHI via Fax, numbers should be programmed to minimize the potential for error. These numbers should be checked periodically to insure that they remain valid numbers. All Faxes containing PHI must include a separate cover sheet. Post-it notes are not an acceptable cover sheet. The Fax cover sheet should include AT LEAST the following information:
- DPH or other appropriate logo
- Recipient name, fax, and phone number
- Sender name and phone number
- Subject
- Date
- Number of pages (including the cover page)
- Confidentiality statement

II. Fax Transmission of Protected Health Information

A. Request for transmission of medical record information to external facilities.

STAT requests to other healthcare facilities:

a. Faxed medical records information may be provided to another health care facility (for direct patient care) with the exception of HIV related information, which will not be faxed without the appropriate patient authorization.

b. Faxed PHI shall be limited to the minimum necessary amount of PHI to perform the intended task.

c. PHI shall only be faxed to confirmed fax numbers, and shall not be sent to distribution lists.

After-hours and weekends:

If an emergency exists, information may be faxed, with the exception of HIV related information by the nursing office. The completed transmission form will be forwarded to H.I.S.

All other requests:

For external release of medical record information, including information to be provided to referring agencies, are to be forwarded to the "Release of Information
Unit of H.I.S. The staff is trained in the Federal and State Regulations that govern authorization and release of medical record information. The transmission documentation will be part of the correspondence section of the patient’s record.

III. Other Fax Transmissions

A. For external release of medical record information, including information to be provided to referring agencies, are to be forwarded to the "Release of Information Unit of H.I.S. The staff is trained in the Federal and State Regulations that govern authorization and release of medical record information. The transmission documentation will be part of the correspondence section of the patient’s medical record.

IV. The following information is prohibited from being faxed:

A. Any patient care document reflecting any of these conditions or diagnoses:

1. AIDS/HIV related conditions
2. Sexually transmitted diseases
3. Drug or alcohol abuse
4. Psychiatric condition

B. Any document reflecting peer review or risk management information.

C. Medical record information in response to requests from anyone other than direct patient providers. This prohibition includes requests from insurance companies, attorneys, and employers.

V. Personnel

Staff assigned to the Release of Information Unit will have the responsibility for carrying out the procedures relating to the transmission and receipt of fax transmissions.

VI. Pre-Transmittal Preparation

A. Verify the fax number of the intended recipient.

B. Verify that there is immediate availability of an authorized recipient on standby to receive the transmission.

C. Prepare a transmittal cover sheet.

VII. Post-Transmittal Follow-Up

A. Receive acknowledgment of receipt of transmission.
B. Place copy of cover sheet and receipt of transmittal acknowledgment in the correspondence section of the patient's chart.

VIII. Receipt of Fax Transmission

A. Remove material from fax machine immediately.
B. Count number of pages received.
C. Check for accuracy of the patient identification to be sure all documents received are intended for Laguna Honda Hospital.
D. Send verification of receipt of the information if this has been requested by the sender.
E. Notify the intended receiver that material has arrived and is ready for pick-up.

IX. Misdirected Fax Transmission

A. Receipt of misdirected transmission
   1. Notify sender of the misdirection.
   2. If transmission is not needed, destroy by shredding.

B. Transmittal of material that inadvertently becomes misdirected.
   1. Obtain the fax number of the unintended receiver (available on the internal fax logging system).
   2. Immediately transmit a request to this unintended receiver and ask that the material be destroyed immediately or returned by mail.
   3. Document occurrence and submit to supervisor.
   4. Verify the fax number of the intended recipient and complete the transmittal process.
CONTENT AND SEQUENCE OF THE MEDICAL RECORD

ADMISSION RECORD:

POLICY:
The health record shall be developed on admission and maintained for each patient/resident admitted to Laguna Honda Hospital.

PURPOSE:
To facilitate patient care and quality assessment.

PROCEDURE:
1. Attending Physician
   Completes all required medical information as outlined in medical staff bylaws.

2. Health Information Services
   Processes, assembles, analyzes, codes and stores all patient/resident health records according to the department's policies and procedures and compiles needed statistics.

3. All Other Services
   Refer to the respective department's Policy and Procedure section.

Revised: 2009/08/10, 2015/06
Original adoption: 1986/08
CONCURRENT ANALYSIS

CONCURRENT QUANTITATIVE ANALYSIS:

POLICY:
Concurrent quantitative analysis of each patient's/resident's medical record is conducted by the Health Information Services department unit analyst.

PURPOSE:
To facilitate the availability of completed protected health information that may be used for patient/resident care and reimbursement purposes.

PROCEDURE:
Concurrent analysis is performed monthly on each unit.

The following is analyzed by Health Information Services:

Physician Orders:
All orders must be dated, timed and signed by the ordering Physician and noted by the nurse.
Nursing Orders written as ‘NO’ or Nursing order should be signed and noted by a nurse.
A telephone order or Verbal orders must be authenticated by the ordering provider and noted by a nurse.

eCW – Medications dispensed by the pharmacy are ordered in eCW. Telephone encounters have to be authenticated by the ordering provider.
Errors – Ask the physician who made the error to draw one line through the error and an initial.

Thinning – Always keep the most recent three months of protected health information, in the rack chart. All thinnings removed from the rack chart should be filed in HIS file room on the unit immediately.

Deficiencies _ Tag deficiencies and enter them into the Chart deficiency system at the completion of monthly concurrent analysis. Print out deficiency report and send out to physicians.
Admission History and Physical Examination:

History and Physical can be dictated using the following systems: Webmedx, typed directly into LCR (Life time Clinical Record) or typed directly into eCW. There must be a typed and signed H&P in every patient’s chart this includes the following changes in service: SNF to acute and acute to SNF. Acute includes Acute Medical (LAM) and Acute Rehab (LAR). The H&P must contain the following information.

1. Patient and/or decision maker/family has been informed of diagnosis
2. Rehab potential
3. TB screening
4. Discharge Plan

Guidelines for H&P Assignment: The H&P is assigned to the physician who admits the patient even if it is not the attending physician. In the absence of the attending physician, the replacement physician (the night/waken physician or the covering physician) would be responsible. This applies to all units including LAM and LAR.

Annual Assessment:
Annual Assessment can be dictated using the following systems: WebMedX, typed directly into LCR (Life time Clinical Record) or typed directly into eCW.

Physician Progress Notes:
Physician Progress Notes can be dictated using the following systems: WebMedX, typed directly into LCR (Life time Clinical Record) or typed directly into eCW.

ADVANCE DIRECTIVES
Are completed and signed by the physician. Errors – Ask the person who made the error to draw one line through the mistake and initial.

LABORATORY REPORTS
Laboratory Reports: See LCR (Life time Clinical Record) to see the reports.

Radiology Reports: See LCR (Life time Clinical Record) to see the reports.
**EKG Reports**
These are to be filed in reversed chronological order. Reports are to be signed by the cardiologist interpreting the report. EKG reports must be corresponded with the stamps in the progress notes.

**Pathology Reports**
Pathology reports are done at outside facilities and are filed after the EKG reports in reverse chronological order. They should not be filed in the records from other hospitals. Check the date and medical record number. Reports must be signed by the physician.

These reports must be signed by the surgeon who performed the operation. Operative reports are also filed in reversed chronological order.

Consent Form - A consent form signed by the patient for performing the operation must be in the chart.

**Nutrition Screening Form**
The dietitian documents the initial nutritional assessment on the Nutritional Screening form and places it in the medical record. The dietitian assesses all SNF residents within 14 days of admission. All REHAB residents are assessed within 7 days; ACUTE patients are screened within 72 hours. Residents readmitted within 3 days will be reassessed within 14 days. Exception: Resident is discharged in less than the time allotted.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Nursing Admission Assessment**
There must be one in every chart filed in the nurses’ notes section.
Thinning – This form remains in the record permanently.

Deficiencies: HIS does not analyze the record for ancillary deficiency.
**Graphic Record**
The Graphic Record is filed in chronological order and can also be located in LCR.

Blood Pressure – B/P should be done at least once a month unless otherwise ordered.

Thinning – Always keep at least the most recent six months in the rack chart and months in the drawer. These thinnings are to be filed immediately if brought up to H.I.S. These thinnings should not be sitting around.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Integrated Notes**
All notes must be signed and dated by the nurse or ancillary provider.

Thinning – Always keep at least the most recent three months in the rack chart. These thinnings are to be filed immediately in the HIS file room on the unit. These thinnings should not be sitting around.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**MDS**
15 months-worth must be filed on the nurses unit at all times.

**Medication Record and Treatment Record**
Medication Record generated from QS1 and HIS.
The time and dose of drug administered to the patient shall be properly recorded in each patient’s medical record by the RN or LVN who administered the drug. All orders must be in writing. Each medication and treatment must be written orders. These records are filed in chronological order in the chart. Treatment records are filed after medication records.

Thinning – Always keep at least the most recent three months in the rack chart and all thinnings should be filed immediately in HIS file room on the unit. These thinnings should not be sitting around.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Weight Record**
This form is filed in chronological order. All patients are to be weighed on admission.
Thinning – Always keep at least the most recent three months in the rack chart and three months in the drawer. And all thinnings should be filed immediately in HIS file room on the unit.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Bowel and Bladder Maintenance Program** (Back of Nursing Admission Assessment) The Bowel and Bladder Maintenance Program sheet must be completed within two (2) weeks of admission. This form remains in the patient’s chart permanently.

Thinning – This form remains in the record.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**DNCR (DAILY NURSING CARE RECORD)**

Thinning – Always keep at least the most recent month in the rack and all thinnings should be filed immediately in HIS file room on the unit.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**MDS Interdisciplinary Quarterly Review**

All sections are to be completed and signed by the appropriate corresponding discipline. The Social worker is responsible for completing both the Social Service section and the Patient/Representative section.

**Therapy Reports**

These therapy progress notes include physical therapy, occupational therapy, speech therapy and audiology. They are to be filed in chronological order and are either hand written or typed.

Progress Notes – All progress notes are dated and signed initial.

Initial Evaluation Note – If services are given for physical or occupational therapy, then there should be two initial evaluation notes; one for each service.

Deficiencies: HIS does not analyze the record for ancillary deficiency. However Evaluation if needs physician signature assign the deficiency. Thinning – Do not thin therapy reports. These thinnings are never brought up to H.I.S.
**Activity Section**

Initial Assessment – This form heads the activity section and is never removed from the rack chart. It must be completed, dated and signed within seven (7) calendar days from the time of the patient’s admission (does not include transfers). It also requires a full signature, not initials.

30-Day Assessment/Leisure Interest Survey (located on the back of the Initial Assessment) – Completed in 30 days from date of admission, signed, and dated by the activity therapist.

Annual Assessment/Leisure Interest Survey – Completed one year from the date of admission and every year thereafter. Current annual is retained in the rack chart. It is completed, dated and signed by the activity therapist.

Quarterly Progress Notes – These notes must be in the patient’s chart completed, dated and signed within a maximum of three, six, nine months from the date of admission. Quarterly progress notes are filed in chronological order.

Respite – Documentation is not required for respite patients. In some cases, attendance records may be kept if a respite patient chooses to participate in activities.

Thinnings – The following documents are filed in the rack chart: -Initial assessment -Current annual assessment and all thinnings should be filed immediately in HIS file room on the unit.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Conditions of Admission**

The Conditions of Admission which also includes acknowledgement of receipt of Bill of Rights must be signed by the patient. If the patient is unable to sign or refuses to sign, it must be stated on the form and two witnesses must sign. If the patient leaves his mark, two witnesses again must sign the form.

Thinning – This form is never removed from the rack chart.

**Social Service**

Social Service Initial Assessment/Psychosocial Assessment – Each resident must have an initial assessment dated and signed by a social worker within five (5) days of the admission. Acute care – due within 24 hours of admission.
Social Service Semi-Annual Assessment Form – The semi-annual assessment must be completed within 6 months from date of admission.

Annual Assessment – Due one year from date of admission.

Quarterly Progress Assessments – Must be completed by the end of the month in which they are due. The Social Service Semi-Annual Assessment Form will suffice for the progress notes.

Deficiencies – Deficiencies: HIS does not analyze the record for ancillary deficiency.

**Registration and Admission Record (Face sheet)**

Each chart must have a face sheet. This form is never removed from the rack chart. This form is occasionally updated with a revision date typed on the top of form. Please review carefully before discarding the old face sheet.

Thinning – This form remains in the chart.

Deficiencies – Deficiencies: HIS does not analyze the record for ancillary deficiency.

Inventory of Patient’s Property

This sheet must be in every patient’s chart. It should be signed by the patient. If the patient is unable to sign or refuses to sign, the form must state this and two witnesses must sign. If the patient leaves a mark, two witnesses again must sign the form. Although the patient may not have any property, this statement should be documented onto the inventory sheet and signed.

Thinning – This form is never to be removed from the rack chart.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

Chronological Record Sheet

This form is updated for each admission, transfer to/from, and discharge.

A. Thinning – This form is never removed from the rack chart.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

Consent Forms/Release Forms

Must be signed by the patient. If the patient is unable to sign, it must be signed by two witnesses.
If the patient leaves his mark, it must also be signed by two witnesses. For example, Refusal to Pay for Laundry or Clothing, Refusal to Participate in Recreational Activities, Refusal to Wear Wrist Band, etc.

Thinning – Do not thin these forms. They are never to be removed from the chart. Also Psychoactive medication form and Aero scout consent form needs to be scanned into Ecw.

Deficiencies: HIS does not analyze the record for ancillary deficiency.

Rx for Appliances and Prosthetic Clinic
Inter-Facility Transfer Report
Blue Cross Physical or Occupational Information
Medi-Cal Treatment and Authorization Payment Request
Correspondence Information
A&D Sheet from SFGH
Records from Other Hospital/Facility
CONCURRENT ANALYSIS

THINNING OF PROTECTED HEALTH INFORMATION DOCUMENTATION FROM UNIT RACK CHART:

POLICY:
Active medical records of all patients shall be thinned routinely or as needed.

PURPOSE:
To maintain an organized clinical record by removing excess protected health information from resident's/patient’s current rack chart, which will enable health care professionals’ access to the current protected health information of the patient.

PROCEDURE:
Only specified documents shall be thinned from the resident's/patient’s rack chart.

To guarantee continuity of protected health information,

Guidelines for Thinning - the following protected health information remains in the active rack record:

<table>
<thead>
<tr>
<th>SECTION/FORMS</th>
<th>TIME PERIOD TO REMAIN IN RACK CHART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Orders</td>
<td>Last 3 Months</td>
</tr>
<tr>
<td>Physician Progress Notes</td>
<td>Last 6 Months</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Labs and Diagnostic Reports</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Integrated Progress Notes</td>
<td>Last 3 Months</td>
</tr>
<tr>
<td>Assessments</td>
<td>Will not thin</td>
</tr>
<tr>
<td>Dietary</td>
<td>Initial and last annual</td>
</tr>
<tr>
<td>Social Service</td>
<td>Initial, last semi-annual &amp; annual</td>
</tr>
<tr>
<td>PASARR</td>
<td>Most current</td>
</tr>
<tr>
<td>DMH/DDS Letters</td>
<td>Most current</td>
</tr>
<tr>
<td>Activity Therapy</td>
<td>Initial and last annual</td>
</tr>
<tr>
<td>MDS</td>
<td>Last Annual (Minimum of 15 months on unit</td>
</tr>
<tr>
<td>Document Type</td>
<td>Retention Period</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Interdisciplinary Meeting Notes</td>
<td>Last 3 Meetings</td>
</tr>
<tr>
<td>Daily Nursing Care Record</td>
<td>1 Month</td>
</tr>
<tr>
<td>Behavioral Monitoring</td>
<td>Last 3 Months</td>
</tr>
<tr>
<td>Medication Record</td>
<td>1 Month</td>
</tr>
<tr>
<td>Treatment Record</td>
<td>1 Month</td>
</tr>
<tr>
<td>Rehab</td>
<td>Will not thin</td>
</tr>
</tbody>
</table>

1. **DOCUMENTATION**

Unauthorized employees will not be allowed to remove protected health information documentation from the rack chart.
PHYSICIAN ORDER PROCESSING

PHYSICIAN ORDER PROCESSING:

POLICY:
Health Information Services (H.I.S.) processes physician orders monthly.

PURPOSE:
To provide physicians, nursing and pharmacy with printed physician orders, medication administration orders and treatment records for each resident/patient.

PROCEDURE:
The three documents produced:
1. Physician Orders
2. Treatment Records
3. Medication Records

I. Pulling of Physician Orders

A. Nursing:
   1. Stamps lower left corner of the original physician’s orders (3part NCR) with patient addressograph card so that patient’s name is visible on the form.
   2. Writes patient’s bed number and allergies on the original physician’s order (3-part NCR) form.
   3. Check to see if the physician’s order sheet is full. The yellow and pink copies of the orders are to be removed from the medical record and forwarded to pharmacy every day for pick-up by HIS personnel.

B. Physicians:
   1. Physician completes pre-printed admission orders.
   2. On 3 part NCR form legibly documents, dates and signs all entries, diagnoses, orders and changes. The 3part NCR form is used as an input/source document.
   3. Reviews and signs printed orders.

C. Health Information Services:
   1. By 1pm each day, the Physician Order typist or Clerk goes to the Pharmacy and picks-up copies of physician’s orders (two copies of NCR form). The second yellow copy is for HIS and the third pink copy is for Pharmacy.
   2. Pulled orders are taken to HIS Physician Order Processing area, for the separation of the yellow copies from the pink copies. The yellow copies remain in HIS, in the Physician Order Processing area and pink copies are sent to the Pharmacy. The HIS Physician Order Processing clerks sort the yellow copies and place them in the designated Unit.
sorter trays. Each group of orders are alphabetized by last name, then first name for updating and processing.

3. The Physician Order Processing typist and clerk are responsible for updating, processing the physician orders, medical records and treatment records using the Clinical Data System on a daily basis.

II. Distribution of Printed Orders

A. Health Information Services:

1. Upon completion of the printing of the orders, the processing clerk and typist distributes one (1) set of the physician orders, the treatment records and the medication records to the units.

B. Nursing:

1. The Head Nurse reviews printed orders for accuracy and notifies the processing clerk and typist of any errors by either:
   a. Calling the HIS Physician Order Processing area following the delivery to request a corrected copy for the same month or
   b. Noting corrections directly onto the Physician Order forms, to indicate a request for a corrected print copy for the next month’s batch or,
   c. Completing a special corrections form, by listing all of the patients with Physician Orders that contain errors and what the changes should be. The changes will show on the next month’s batch of Physician Orders.

2. Nursing will sign on the “Reviewed By” line after reviewing orders.

3. Nursing will note the orders after the Physician reviews and signs the orders.

C. Physician:

1. Will review, sign and date the new printed Physician Orders that are correct.

D. Health Information Services

1. The Physician Order Processing clerk and typist addresses all calls, inquiries and questions from the units regarding physician order processing.

III. Procedure for Obtaining Physician Orders

A. Physician order sheets are processed daily, each month. The processing should be completed by the last work day of each month. The LVNs and Unit Clerks are responsible for pulling the physician order sheets for each patient in the unit and forwarding all of the physician’s orders to the Pharmacy, where the orders are picked up by either the HIS File clerk, Physician Order Processing Clerk or Typist on a daily basis.

1. On the 19th of each month, the Physician Order Processing Typist or Clerk goes to the units and delivers both blank and new printed physician orders (3-part NCR) to the Nursing staff. The Head Nurse or Nurse Manager is informed that the orders will be pulled that day. The Nursing staff is also reminded that all printed orders must be
signed and dated by the Physician before the Physician Orders are removed from the unit. If the orders are signed and dated the Nursing staff will have to forward the orders to HIS the next day or as soon as possible.

2. Pull the patient’s rack chart and remove the physician orders (3-part NCR form). Remove the following copies yellow and pink from the rack chart. Leave the white copy of the physician orders in the rack chart. If there is any blank space appearing on the Physician Order form, draw a line through the blank area of the page, prior to pulling the yellow and pink copies of the Physician Orders to prevent a Physician from writing any additional orders on the form after the copies have been removed.
   a. All copies of the Physician Orders should have the yellow and pink copies pulled including: Pass Orders, Enteral Nutrition Orders, Tracheostomy Care Orders, Restraint Orders, Warfarin Orders, and the Anti-Neoplastic/Cytotoxic Medication Orders.
   b. Remove a copy of the previous month’s printed Physician Orders (processed orders). Keep the previously processed Physician Order copies together with the newly pulled NCR yellow and pink colored copies.
   c. Make sure that the most complete copy of the printed Physician’s Orders that has the signatures of the Unit Physician, the Nurse and the Pharmacist, remains in the rack chart.
   d. The printed copy of the Physician Orders is filed by the Unit Clerk or a Nurse, so be sure to look through the orders section of the rack chart to validate that no other copies of the 3-part NCR Physician Orders have been missed.

3. Reinsert back into the rack chart, the white copy of the written orders in the order they were removed from the patient’s chart. Re-file the patient’s rack chart in the same location on the rack chart holder.

4. Repeat the steps as outlined above until all of the copies have been removed from each rack chart.

5. Check with the Nurse in charge of that unit for rack charts of residents/patients whose rack charts were not available while you were on the unit. If the rack chart is missing from the rack or not available, look for the addressograph card of missing/unavailable resident/patient chart and write down the name and medical record number and remember to go back to the unit at another time to pull the Physician orders. The Nurse or the Unit Clerk can also forward the remaining physician’s orders to HIS.

5. Separate the Pharmacy copies from the Health Information Services Physician Order Processing area copies.

6. Secure the copies with a rubber band (the previous month’s copy of printed order and the yellow and pink copies) and take the copies to the Pharmacy. Be sure that the Pharmacy also gets their copy of the “late pulled orders” by either having the Nurse Manager/ Head Nurse send the copies directly to the Pharmacy via interoffice mail or request that someone from the Unit take the copies to the Pharmacy.
7. The HIS Physician Order Processing Clerk or Typist will sort, batch and then separate the yellow and pink copies that have been picked up from the Units.

8. Place the yellow copies of each unit in alphabetical order by the resident’s/patient’s last name.

IV. Printing Process for: Physician’s Orders, Medication Records and Treatment Records

A. Physician Order Processing Clerk or the Typist prints the physician’s orders, the medication records (MAR) and the treatment records (TAR) after the Physician Orders have been processed, typed and updated for all Units. This process occurs before the end of each month. The sets of Physician Orders are delivered to the units where they are reviewed by the Nursing staff for accuracy, identification of any errors and identification of required corrections. The edited Physician Orders are forwarded to the HIS Department to address the requested edits and correction and re-printing of the corrected Physician Orders.

B. The Admitting Orders and Readmit Orders that were picked up from all of the units, are also processed and printed at the end of each month.

C. The Physician Order’s Clerk or typist will also print the Pharmacy MARs using the QS/1 system that is physically located in the Pharmacy department. The Pharmacy MARs are interfiled by units for delivery with the printed Physician Order sets.

V. Distribution of Physician Orders (3-Part NCR)

A. First copy (white) stays in the resident’s/patient’s chart.

B. Second copy (yellow) to H.I.S. for storage in file cabinet.

C. Third copy (pink) to the Pharmacy department.

I) Delivery of Physician Orders

A. The Physician Order’s Clerk or Typist will print all Physician Orders that have been edited, updated and corrected. After the printing has been completed, the Physician Order’s Clerk or Typist will sort the documents, by unit in preparation for delivery.

B. All of the sorted Physician Orders are delivered to the units by either the HIS File clerk, Physician Order Processing Clerk or the Physician Order Processing Typist.

VI. PHYSICIAN ORDER PROCESSING CORRECTION REQUESTS:

A copy of a correction request form is provided to the units, upon request and are completed by the Nursing staff.
The correction request form contains the following information: unit name, date requested by the unit and the extension number. The patient name, date or month of the order, corrections/changes to be made and in which area of the form as well as which type of form [Physician Orders, Medication Orders and/or Treatment Orders].

After the corrections have been completed, the Physician Order Processing Clerk or Typist will complete the following items on the form: the date received, corrections completed by whom and the date when the correction is completed.

When the requested corrections have been completed, the corrections request form is filed along with the processed orders on each unit, into a filing cabinet located in the HIS Department.

Revised: 2009/08/10, 2015/07/19
Original adoption: 1986/08
TRANSCRIBED REPORTS

GENERAL POLICIES:

POLICY:

Health Information Services (H.I.S.) provides the following options for Clinicians to produce dictated, transcribed or direct entry typed reports:

a. A centralized dictation system with transcriptionist on site in the Health Information Services department.
b. Transcription services provided by a transcription vendor that is accessible 24 hours a day, seven days a week.
c. Ability to directly type a report into either the Live Clinical Repository (LCR) or e-Clinical Works (eCW)

PURPOSE:

To support the documentation process associated with quality patient care through accurate transcribed reports.

PROCEDURE:

I. Reports dictated and transcribed shall routinely contain the following information on each report:

A. Name of hospital
B. Location/Unit
C. Date of Service
D. Medical Record Number
E. Type of report
F. Patient name
G. Date dictated
H. Date transcribed
I. Initials of transcriptionist
J. Signature of dictator

II. Scope of Service

The following reports may be dictated:

A. History & Physical
B. Discharge Summary
C. Consultation Reports
D. Operative Report
E. Clinic Notes
F. Annual Patient Review
G. Special Reports

III. Authorized Users and Access

A. Physicians responsible for dictating reports/documents will be authorized to access the dictation system.
B. Each authorized dictation user will be provided with general instructions for using the system.
C. Access to material dictated but not transcribed is limited to:
   1. Transcriptionists only.

IV. Processing Time and Priority Designation

A. All dictation shall be transcribed and placed in the appropriate patient medical record by H.I.S. Personnel.
B. The various turnaround times for transcribing are established in recognition of: time sensitivity, value of the information for patient care.
C. Routine dictation shall meet the turn-around-times.
D. STAT reports may be dictated and either the outside transcription service or HIS transcriptionist will be notified for immediate transcribing of the dictation. During the HIS Department’s operation hours (6:00 AM to 4:30 PM,).
E. Physicians must notify the HIS transcription unit or the outside transcription services prior to dictating any STAT report.
F. STAT reports dictated after the HIS Department operation hours will be processed immediately at the beginning of the next work day, unless the Physician notifies the transcription service of the STAT report.
G. The turnaround time for a STAT reports is three (3) hours.
H. The following types of reports may be considered for STAT work status:
   1. Discharge summaries for patients being transferred.
   2. History & Physicals for patients scheduled for surgery.
   3. Any dictation deemed urgent.
I. Any questions regarding STAT dictations should be referred to the HIS department.
V. Access and Location of Dictation Equipment - Dictation system will be provided on a continuous basis (24 hours a day/seven days a week) via direct telephone access.

A. A special dictation station is available in the Outpatient Clinic:

VI. Reports typed directly into the Live Clinical Repository (LCR):

Clinicians may choose to type their reports directly into the Live Clinical Repository (LCR) System. The Clinician will make a notation in the hard copy medical record indicating that the Report has been typed into the LCR system.

VII. Reports typed directly into the e-Clinical Works (eCW) system:

Clinicians may choose to type their reports directly into the e-Clinical Works (eCW) system. The Clinician will make a notation in the hard copy of the medical record referring the viewing to find The report in eCW.

VIII. Transcription Distribution:

A. Discharge Summaries:
Transcribed discharge summaries are printed on the neighborhood/unit and also in the Health Information Services department at the Physician Completion desk, for all patient types.

Discharge Summaries directly typed into either LCR or eCW will be printed in the Health Information Services department and filed into the hard copy medical record.

B. History & Physical:

Dictated and transcribed H&P reports will be printed in the Health Information Services Department and filed into the medical records.

C. Advance Directives
Advance Directive report may be dictated and transcribed, or typed directly into the LCR or eCW.

Revised: 2009/08/10, 2015/07/21
Original adoption: 1986/08
RECORD REQUESTS

RETRIEVAL OF MEDICAL RECORDS:

POLICY:

To retrieval of protected health information.

PURPOSE:

To assure that all protected health information is maintained and easily accessible to the Health Information Services department personnel, medical staff and other health providers authorized to access/use the protected health information.

PROCEDURE:

1. Retrieval of Protected Health Information
   a. Protected Health Information (PHI) of discharged patients must be received by the Health Information Services Department within 48 hours of discharge in order for Health Information personnel process the record.
   b. Protected Health Information (PHI) of discharged patients include the contents of the rack chart, thinned protected health information, and any other loose documents associated with the patient’s stay and services.

2. Chart Requests
   a. The Health Information Services Department must be notified one (1) day in advance for any chart requests. Requests for same-day deliveries are accepted if the call is made by 8:00 a.m. Charts will not be delivered outside of the scheduled delivery time, unless caller identifies the request as an emergency or STAT chart request. Health Information personnel are available on weekdays between the hours of 8:00 a.m. - 5:00 p.m.

      All charts requested from the Health Information Services Department must be returned within 72 hours.

      b. When 10 or more records are requested for, i.e., special studies, audits, etc., the "Request for Health Information Special Studies" form must be completed and submitted to the Health Information Services department one (1) week prior to the requested date.
Revised: 2009/08/10, 2015/07
Original adoption: 1986/08
RELEASE OF INFORMATION

AUTORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

POLICY:
It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to comply with the Department of Public Health’s (DPH) policy, “Authorization for Use and Disclosure of Protected Health Information: (See Appendix A). It is also the policy to have the resident/patient or resident complete the appropriate form in order to authorize the disclosure and/or use of individually identifiable health information (see Appendix B-1 and B-2).

PURPOSE:
To uphold the confidentiality of Health Record Information and protect the individual’s right to privacy in the collection and disclosure of protected health information (PHI) in accordance with:
A. California Civil Code 56, et seq. (The Confidentiality of Medical Information Act),
B. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996
C. Department of Public Health’s (DPH) policy
D. Any other federal and state statutes which provide additional protection for certain medical, mental health and substance abuse information.

In situations where laws conflict or overlap, the law that provides the resident/patient with the greater protection will take precedence.

DPH POLICY: AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

It is policy of the San Francisco Department of Public Health (DPH) to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other applicable state and federal confidentiality laws by obtaining authorization before using or disclosing protected health information (PHI), unless the use or disclosure is specifically permitted or required by law.

This policy pertains to all individuals who have access to, use, or disclose Department of Public Health PHI. DPH divisions or units may enforce stricter authorization requirements for the use or disclosure of PHI than those set forth in this policy.

DEFINITIONS
Use: The sharing, employment, application, utilization, examination, or analysis of protected health information within DPH, its affiliates, or its contract providers.

Disclosure: The release, transfer, provision of access to, or divulging in any other manner of protected health information.

Authorization: The formal consent document releasing PHI from the records of an entity covered by the privacy provisions of HIPAA.

PROCEDURE

I. Minimum Necessary Rule
   A. General Rule: When disclosing PHI, or when requesting PHI from another covered entity, providers must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
   B. Exceptions
      1. Disclosures for, or uses related to, treatment (see Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes);
2. Disclosures to the resident/patient or resident/patient representative pursuant to resident/patient access rights;

3. Uses or disclosures made pursuant to a valid HIPAA authorization which describes the PHI to be disclosed;
4. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to an investigation or compliance review; and
5. Other uses or disclosures that are required by law and that commonly prescribe what information must be disclosed (e.g., pursuant to a subpoena or court order, reporting child abuse or any other use or disclosure of PHI that is required by law).

II. Administration of Authorizations

A. An authorization is required in the following situations (see Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes):

1. Per the HIPAA Privacy Rule for use of PHI by DPH, its providers, its affiliates and its contract providers for purposes not related to treatment, payment or health care operations.
2. Per 42 CFR Part 2, for the disclosure of information pertaining to an individual’s treatment in a substance abuse program, except in a medical emergency.
3. Per DPH Policy, for the disclosure of information pertaining to sexually transmitted disease treatment from the DPH City Clinic (Municipal STD Clinic) or other communicable disease treatment by DPH Community Health Epidemiology when not related to infectious disease monitoring procedures.
4. Per CCSF Local Share Mandate established with the California Office of AIDS, for the disclosure of information pertaining to an individual’s treatment in a CCSF HIV Health Service program outside that network of providers.

B. Valid Authorization Forms

1. When authorization is required, all DPH divisions/units and providers shall obtain resident/patient/client/resident authorization using the standard DPH Authorization to Release Protected Health Information form.
2. Due to strict HIPAA requirements for an authorization form to be valid (see Attachment B), any DPH provider that plans to develop a different authorization form must have that form approved by a DPH Privacy Officer.
3. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be returned to the sender.
4. All researchers who request permission to conduct a study with human subjects in the DPH must include with the request a DPH standard authorization for the use of the PHI generated from the study. This standard authorization must contain all elements required by HIPAA. Refer to DPH Privacy Policy “Conduct of Research” for more information.

C. Invalid Authorizations

An authorization is not valid if:
1. The expiration date has passed or the expiration event is known by DPH to have occurred;
2. The authorization has not been filled out completely;
3. The authorization is known by DPH to have been revoked;
4. Material information in the authorization is known by the DPH to be false;
5. The authorization was improperly combined with another document; or
6. The authorization is not in 14-point font type.

D. Documenting Authorizations
1. All authorizations for use and disclosure of DPH PHI should be filed in the correspondence section of the medical record of the individual concerned.
2. A copy of the completed authorization form should be offered to the resident/patient.

E. Compound Authorizations
1. General Rule: DPH authorizations may not be combined with any other document to create a “compound authorization.”
2. Exception: An authorization for the disclosure of DPH PHI generated by research may be combined with the required informed consent for participation in the research.

F. Making Treatment, Payment, Enrollment, or Eligibility Conditional Upon an Authorization
1. General Rule
   a. DPH shall not make treatment, payment, enrollment in a health plan or eligibility for benefits conditional upon the resident/patient, resident or client’s execution of an authorization.
2. Exceptions
   a. For treatment as part of research in which the individual will participate as a human subject.
   b. When the purpose is to create DPH PHI to disclose to a third party (e.g., pre-enrollment physicals).
   c. When the program is designed for a specific population whose participation is conditional upon authorization (e.g., Behavioral Health Court).
   d. A DPH-sponsored or DPH-affiliated health plan may make enrollment or eligibility for benefits conditional upon authorization, provided that the authorization (i) is obtained prior to enrollment and (ii) relates specifically to the individual or to underwriting or risk-rating determinations.

III. Oral Agreements
DPH may rely upon an individual’s oral approval to disclose, restrict or prohibit the use of PHI under the following circumstances:
A. For an resident/patient facility directory;
B. For involvement in the individual’s care by next-of-kin, family members, domestic partners and/or close personal friends; and
C. To notify a family member, personal representative or other person responsible for the care of the individual about the individual’s location, general condition or death.

V. Minors
VI. Deceased Residents/Resident/Patient
For deceased residents/patients, the resident/patient representative (next of kin or executor of estate) has the rights that the resident/patient would have had relative to access and release of the record.

VII. Employment Determinations
Authorization is required for DPH to use or disclose an individual’s PHI for employment determinations. For example, DPH must have the individual’s authorization to disclose the results of a pre-employment physical to an individual’s employer.

VIII. Media and Other Inquiries
A. All media inquiries should be referred immediately to a DPH Privacy Officer and/or the DPH Public Information Officer prior to release of information.
B. No information may be disclosed if the resident/patient has requested that information be withheld. Otherwise, the condition of a resident/patient to the media may be disclosed only if the inquiry specifically contains the resident’s/patient’s name. (See exclusion in F and G below.)
C. A DPH resident’s/patient’s condition may be described only in general terms that do not communicate specific medical information about the individual (e.g., undetermined, good, fair, serious, critical, or deceased).
D. Care should be taken to first notify the DPH resident’s/patient’s next of kin before the fact of death is made public. No additional information about a resident’s/patient’s death, including the cause, date, or time of death, may be made without written authorization from a legal representative of the deceased resident/patient, even if this information has been disclosed to the Medical Examiner or the Death Registrar.
E. Information concerning a DPH resident/patient’s location in the hospital may be
made to facilitate visits by family or friends or for delivery of gifts or flowers if the inquiry includes the resident's/patient's name and there is no instruction from the resident/patient to withhold such information. This information should not be routinely disclosed to the media.

F. Information may not be released to the media about identifiable DPH resident/patient engaged in behavioral health services (including those served in outreach, mental health, substance abuse, HIV, or supportive housing programs). This policy applies to current, previous, and deceased residents/patients and to cases even when the resident/patient has requested or authorized DPH staff to speak to the media.

G. Per DPH policy, brochures or publications developed by DPH-funded programs are not to include identifiable residents/patients in photos or personal stories that disclose their current or past mental health issues or substance use, or engagement in behavioral health services. This policy applies to current, previous, and deceased residents/patients and to cases even where the resident/patient has requested or authorized DPH staff to present them in publications.

IX. Permissible Disclosures Without Authorization for Public Policy Purposes

An authorization is not required in the following situations:

A. For disclosures required by state or federal law.

B. For DPH public health activities specifically permitted or required by law, such as preventing and controlling disease, injury, or disability; providing information to the Food and Drug Administration regarding adverse drug events, tracking health-related products, enabling product recalls, or conducting post-marketing product surveillance.

C. For a work-related injury or illness when the release is to the responsible employer (the individual must be informed of the disclosure); that is, the employer has sent the resident/patient, is paying for the care under workers comp, etc.

D. For reporting victims of abuse or neglect as specifically required under the law.

E. For reporting to a health oversight agency regarding activities authorized by law, including civil, administrative or criminal investigations, proceedings, actions, or inspections, audits, licensure surveys or investigations, or disciplinary actions.

F. For responding to an order of a court or administrative tribunal issuing a subpoena, discovery request or other lawful process.

G. For providing the San Francisco Medical Examiner or a funeral director with information needed to carry out his or her duties as authorized by law.

H. For facilitating organ, eye, or tissue donation and transplantation.

I. For preventing or lessening a serious and imminent threat to the health or safety of a person or the public when the individual to whom the disclosure is made is capable of preventing or lessening the threat.

J. To warn reasonably identifiable victim(s) and notify law enforcement when a resident/patient communicates a serious threat of violence against a reasonably identifiable victim or victims (Tarasoff Duty to Warn).

K. For informing the Department of Veterans Affairs as authorized by law of information needed for determination of eligibility or entitlement to benefits for
an individual following discharge from military service.

L. For disclosing information as authorized by law to provide benefits for work-related injuries and illnesses.

X. Permissible Disclosures Without Authorization for Care Coordination Purposes Not Otherwise Covered

A. As of January 1, 2009, if a minor is a dependent or ward of Juvenile Court, a general health care provider (Civil Code 56.103) or mental health care provider (W&I Code 5328.04) may disclose protected health information to a County social worker, probation officer or other adult who has care and custody of a minor in order to coordinate health care services and treatment (e.g., information about appointments, treatment plans, follow-up care, etc.).

XI. Permissible Disclosures of General Health Information Without Authorization for Law Enforcement Purposes

An authorization is not required in the following situations:

A. When the disclosure of PHI is made in response to a law enforcement official's request for such information for the purpose of IDENTIFYING or LOCATING a suspect, fugitive, material witness, or missing person and the PHI is limited to:
   (a) Name and address
   (b) Date and place of birth
   (c) Social Security number
   (d) ABO blood type and Rh factor
   (e) Type of injury
   (f) Date and time of treatment
   (g) Date and time of death, if applicable
   (h) Description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos

B. PHI related to an individual’s DNA, DNA analysis, dental records, or typing, sampling, or analysis of body fluids or tissues MAY NOT be disclosed, excluding ABO blood type and Rh factor.

C. When the disclosure of PHI is made in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, provided that:
   1. The law enforcement official represents that immediate law enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure, and
   2. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred and such information is not intended to be used against the victim.

D. When the disclosure is made to a law enforcement official about a decedent suspected to have died as the result of criminal conduct, excluding Mental Health clients (unless in a state hospital).
E. When the disclosure is made to a law enforcement official about an individual, the PHI of whom constitutes evidence of criminal conduct that occurred on the premises of DPH.

F. When the disclosure is made to a law enforcement authority to identify or apprehend an individual because of a statement made by the individual admitting participation in a violent crime that caused serious harm to a victim, excluding mental health information.

G. When the disclosure is made to a law enforcement authority where it appears from all circumstances that the individual has escaped from a correctional institution or from lawful custody.

H. When the disclosure is made to a correctional institution or law enforcement official having lawful custody of an inmate or other individual for:
   (a) The provision of healthcare to such individual (disclosures may include mental health or HIV information as well);
   (b) The health and safety of such individual or other inmates;
   (c) The health and safety of the officers or employees or of others at the correctional institution;
   (d) The health and safety of individuals and officers responsible for the transport or transfer of inmates from one correctional or health care setting to another;
   (e) Law enforcement on the premises of the correctional institution; or
   (f) The administration and maintenance of the safety, security, and good order of the correctional institution.

X. SPECIAL REQUIREMENTS FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITY INFORMATION, SUBSTANCE ABUSE INFORMATION, SEXUALLY TRANSMITTED DISEASE INFORMATION, AND HEALTH INFORMATION OF MINORS

A. Mental Health Information
   1. Although the federal privacy rule largely does not make a distinction between medical and mental health information, California state law does provide special protections for mental health information. Mental health information may be shared among DPH providers and contractors for the purposes of treatment. All other uses and disclosures require the specific authorization of the patient to disclose mental health information.
   2. Mental health information includes psychotherapy notes, medication prescription and monitoring, counseling session start and stop times, modalities/frequencies of treatment, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis, or progress recorded by mental health professionals.
   3. Generally, disclosures of mental health information require the specific authorization from the patient for release. The state law that addresses the
confidentiality of mental health information is the California Welfare and Institutions Code Section 5328 et seq., known as the Lanterman-Petris-Short Act ("LPS Act"). Questions regarding the use or disclosure of mental health information should be referred to the DPH Privacy Officer.

B. Substance Abuse Information

1. Although the federal Privacy Rule does not make a distinction between medical and substance abuse information, other federal statutes and California state laws do provide statutory restrictions for the release of information developed or obtained in the course of providing substance abuse treatment in federally funded substance abuse programs. Substance abuse treatment provided in the course of general medical treatment is not subject to these provisions. Therefore, substance abuse information may be shared among DPH providers and to its contracted providers without authorization of the patient for patient care purposes. For example, substance abuse treatment information may be shared from the General Medical Clinic to Castro-Mission Health Center or to a substance abuse provider contracted by Community Programs. However, the contracted substance abuse provider must obtain the patient’s authorization to share information back to the General Medical Clinic or Castro-Mission Health Center. All other uses and disclosures require specific substance abuse authorization from the patient.

2. Information pertaining to substance abuse patients is subject to special protection under federal statute 42 U.S.C. Section 290dd-2 and under federal regulations found in the "Confidentiality of Alcohol and Drug Abuse Patient Records," 42 C.F.R. part 2. Additionally, California Health and Safety Code Section 11977 provides special protections to information of certain drug abuse programs. The LPS Act may also apply if the patient receives services such as involuntary evaluation and treatment because the patient is gravely disabled or dangerous to self or others as a result of abuse of alcohol, narcotics or other dangerous drugs.

3. These federal and state statutes require written authorization for disclosure of substance abuse information in certain circumstances and other special protections for substance abuse information. In these situations, the state law must be followed. Questions regarding the use or disclosure of substance abuse information should be referred to the DPH Privacy Officer.

C. Sexually Transmitted Diseases and HIV/AIDS Information

Per state law HIV test results can not be disclosed without specific, written authorization from the patient except for purposes of diagnosis, care, or treatment of the patient by DPH providers.
Per DPH policy, PHI from City Clinic (Municipal STD Clinic) and Community Health Epidemiology unit is only disclosed upon the specific authorization of the patient when not used for communicable disease monitoring and reporting purposes.

APPENDICES

Appendix A: DPH Policy- "Authorization for Use and Disclosure of Protected Health Information"
Appendix A-1: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes
Appendix B-1: Authorization to Disclose Health Information
Appendix B-2: Authorization to Disclose Health Information Psychotherapy Notes
Appendix C. Sharing Public Health Information for Treatment Purposes
Appendix D. Required Elements of an Authorization to Release Protected Health Information Form

CROSS REFERENCES

LHH Hospitalwide Policies:
21-04 HIPAA Compliance
21-01 Medical Records Information: Confidentiality and Release

Revised:
Original adoption: 2015/08
RELEASE OF INFORMATION

ACCESS TO HEALTH RECORDS BY OMBUDSMAN:

POLICY:
The goal of the State Long-Term Care Ombudsman Program is to advocate for the rights of all residents of long-term care facilities. The Ombudsman’s advocacy role takes two forms: 1) to receive and resolve individual complaints and issues by, or on behalf of, these residents; and 2) to pursue resident advocacy in the long-term care system, its laws, policies, regulations, and administration through public education and consensus building. Residents or their family members can file a complaint directly with the local Long-Term Care Ombudsman or by calling the CRISIS line.

The Office of the Ombudsman does not conduct formal investigations; does not change rules, policies, or procedures; does not participate in any formal hearing or grievance process; does not supersede the authority of other CDCR officials; does not disclose and may not be required to disclose information provided in confidence, except to address an imminent risk of serious harm where there is no other responsible option; and does not engage in any activity that might be perceived by others as advocacy for any individual.

The Office of the Ombudsman listens, answers your questions, analyzes your situation, explains CDCR policies and procedures, advocates for the fairness of a process as opposed to advocating for an individual party, provides information and at times advice and develops options, suggests appropriate referrals, apprises administration of significant trends and may recommend changes in policies and procedures.

Representatives of the Ombudsman office shall have the right of access to both the patient and to the patient’s health record in long-term care facilities for the purpose of hearing, investigating and resolving complaints of, and rendering advice to, elderly individuals who are patients or residents of the facilities at any time deemed necessary and reasonable by testate Ombudsman to carry out the provisions of this chapter [California Welfare and Institutions Code, Section 9724: Notwithstanding Section 56 of the Civil Code, in order for the office to carry out its responsibilities under this chapter, the office shall have access to the medical or personal records of a patient or resident of a long-term care facility that are retained by the facility, under the following conditions: (a) If the patient or resident has the ability to write, access may only be obtained by the written consent of the patient or resident. (b) If the patient or resident is unable to write, oral consent may be given in the presence of a third party as witness. (c) If the patient or resident is under a California guardianship or conservatorship of the person that provides the guardian or conservator with the authority to approve review of records, the office shall obtain the permission of the guardian or conservator for review of the records, unless any of the following apply: (1) The existence of the guardianship
or conservatorship is unknown to the office or the facility. (2) The guardian or conservator cannot be reached within three working days. (3) The office has reason to believe the guardian or conservator is not acting in the best interests of the ward or the conservatee. (d) If the patient or resident is unable to express written or oral consent and there is no guardian or conservator, or the notification of the guardian or conservator is not applicable for reasons set forth in subdivision (c), inspection of records may be made by full-time state employees of the office ombudsman coordinator, and by ombudsmen qualified by medical training and with the approval of the ombudsman coordinator or the State Ombudsman, when there is sufficient cause for the inspection. The licensee may, at his or her discretion, permit other representatives of the office to inspect records in the performance of their official duties. Copies may be reproduced by the office. The licensee and facility personnel who disclose records pursuant to this subdivision shall not be liable for the disclosure. If investigation of records is sought pursuant to this subdivision, the ombudsman shall, upon request, produce a statement signed by the ombudsman coordinator authorizing the ombudsman to review the records. (e) Facilities providing copies of records pursuant to this section may charge the actual copying cost for each page copied. (f) Upon request by the office, a long-term care facility shall provide to the office the name, address, and telephone number of the conservator, legal representative, or next-of-kin of any patient or resident.

The ombudsman seeking access may be either an employee of the office or a volunteer who has not had any special medical training.

PURPOSE:

1. To comply with current California and Federal law
2. Access to records includes both the right to inspect original records and the right to obtain copies.

PROCEDURE:

1. The ombudsman shall have access to the medical or personal records of a patient or resident of a long-term care facility which are retained by the facility, under the following conditions:
   a. If the patient or resident has the ability to write, access may only be obtained by the written consent of the patient or resident.
   b. If the patient or resident is unable to write or sign, oral consent may be given in the presence of a third party as witness, i.e., not the person to whom consent is being given.
   c. If the patient or resident is under a California guardianship or conservatorship of the person, which provides the guardian or conservator with the authority to approve
review of records, the office shall obtain the permission of the guardian or conservator for review of the records, unless any of the following apply:

i. The existence of the guardianship or conservatorship is unknown to the office or the facility.

ii. The guardian or conservator cannot be reached within three working days.

iii. The office has reason to believe the guardian or conservator is not acting in the best interest of the ward or the conservatee.

d.  

2. Processing Copies of Protected Health Information

Upon receipt of an authorized written request:

a. Locate record

i. If record cannot be located after 72 hours.
   - seek the assistance of other HIS employees in locating the medical record
   - If still unable to locate the record, send a notice to the requestor that there is a delay in complying with the request, due to record unavailable.
   - Enter information into the Release of Information module of the Clintegrity system and document that contact was made to the requestor, the requestor’s name and the date.

ii. When the medical record is located, document this information into the Clintegrity Release of Information module.

iii. Verify that signature on the request matches signature in chart or, in the case deceased, the beneficiary or next of kin should match that which is in the chart. Conservators or guardians should send a copy of their appointment papers when requesting copies. Since psychiatric conservatorship must be renewed annually, check to make sure that the appointment is currently active and valid.

b. Ascertain the type of record being requested and referred to separate section of procedures if record is of the below listed types. If standard chart, proceed to step C.

i. Minor patient – see 13.01; Section V.

ii. Mental Health Patient – see 13.07

iii. Alcohol and Drug Abuse Patient – see 13.08

c. Notify the Attending Physician or Psychologist of written requests from former and forward the chart for review before access is granted.

i. If the Attending Physician denies access, refer to Access Denied process.

ii. If the Attending Physician elects to provide a summary, refer to procedures, Summary Alternative.

d. Copy requested documents from the medical record:
i.

ii. Enter information into Clintegrity’s Release of Information module

iii. File the authorization form in the resident’s medical record.

e. When payment is received

i. 1. Mail copy of the medical record to the requestor by certified mail.

3. **Processing Requests for Access to Records**

Upon receipt of an authorized written request:

a. **Locate record**

   i. If record cannot be located after 72 hours, seek the assistance of other HIS employees in locating the medical record

   ii. If still unable to locate the record, send a notice to the requestor that there is a delay in complying with the request, due to record unavailability.

   iii. Enter requestor information into the Release of Information module of the Clintegrity system and document that contact was made to the requestor, the requestor’s name and the date.

   iv. When the medical record is located, document this information into the Clintegrity Release of Information module.

b. **Verify that signature on the request matches signature in chart or, in the case of a deceased patient, the beneficiary or next of kin should match that which is in the chart. Conservators or guardians should send a copy of their appointment papers when requesting copies. Since psychiatric conservatorship must be renewed annually, check Ascertain the type of record being requested and refer to the separate section of procedures if record is of the below listed types. If standard chart, proceed to step C.**

   i. Minor patient – see 13.01; Section V

   ii. Mental Health Patient – see 13.07

   iii. Alcohol and Drug Abuse Patient – see 13.08

c. **Notify the Attending Physician or Psychologist of written requests from former and forward the chart for review before access is granted.**

   iii. If the Attending Physician denies access, refer to Access Denied process.

   iv. If the Attending Physician elects to provide a summary, refer to procedures, Summary Alternative.

1.

d. **If access is authorized by the Medical Director:**

   i. Send letter to requestor – Acknowledgment of Request for Inspection

   ii. Enter remaining information into the Clintegrity Release of Information Module.
iii. File a copy of the authorization form into the patient’s medical record.

iv. Place a copy of Access to Patient Record Form in chart

v. Remove from chart:
   - Material not pertaining to the resident.
   - Information given in confidence.
   - Material not specified in the written authorization.

vi. When patient or representative arrives to review record:
   - Collect payment (money order)
   - Request signature(s) on Access to Record Form
   - Request and verify resident’s or representative’s identification with photograph (e.g. driver’s license).
   - Pull the record.
   - Stay with resident or representative during review.
   - If copies are requested provide the requestor with the request for the copies, log the request into the Clintegrity system, inform the requestor when the copies will be available for pick-up or when the copies will be mailed (within 15 calendar days), and make the copies.

4. Procedure When Access Denied

Under HIPAA, if a provider denies access, in whole or in part, it must give the individual a written notice (within five working days, as required by California Law) including the following information:

a. An explanation of the basis for the denial.

b. A description of how the individual may complain to the provider or to the Secretary of DHHS. The description of to complain to the provider must include the name or title and phone number of the contact person or office responsible for handling privacy complaints; and

c. If applicable, an explanation of the patient’s review rights and how to pursue those rights [45 C.F.R. Section 164.524(d) (2)].

If access is denied because the Attending Physician has opted to dictate a summary of the medical record, refer to Summary Alternatives.

The Attending Physician will make the decisions of denial of access and will inform H.I.S. of this decision. The requestor and/or resident will be notified of denial of access to records.

Denial of access must be noted in the resident’s medical record, including the date of the request, the reason for adverse or detrimental consequences to the resident if the resident was permitted access.
Ascertain reason for denial (refer to specific guidelines for the following):

i. Minor Resident, 16.16.
ii. Mental Health Patient 16.17 – Applies to mental health records and also applies to psychotherapy notes not separately maintained or otherwise not meeting the HIPAA definition of psychotherapy notes [Section A “Psychotherapy Notes,” page 15.24; *California Hospital Association, Consent Manual 2015*].
iii. Alcohol and Drug Abuse Patient, 16.18
iv. X-Ray 16.19

Enter information into Clintegrity Release of Information Module and note the reason for denial. If denial does not meet one of the above criteria, contact the Physician who issued the denial of access and document the Physician’s name and reason for denial into the Clintegrity ROI module.

Notification of denial must be made within the time frame detailed for each of the following: Denial to access – five (5) working days
Denial to copies – fifteen (15) calendar days.

5. **Summary Alternative**

Health & Safety Code 1795 [this code pertains to Chapter 12. Family Notification...make reasonable efforts to contact eh person named in the resident’s admission agreement as the resident's contact person or the resident’s responsible person, within 24 hours after a significant change in the resident’s health... nothing to do with a summary] permits a provider to furnish a summary of the patient record with the patient’s agreement as an alternative to providing access to the actual record. [Section 25256...this pertains to Division 20. Miscellaneous Health and Safety Provisions, Article 14. Green Chemistry section 25256...nothing to do with a summary]

Per the [HIPAA Privacy Rule, Department of Health & Human Services]: Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity’s designated record set. The “designated record set” is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider’s medical and billing records about individuals or a health plan’s enrollment, payment, claims adjudication, and case or medical management record systems. The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, **covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to**
have such denials reviewed by a licensed health care professional for a second opinion.\textsuperscript{57}

a. CONTENTS: The provider may consult with the patient or patient’s legal representative in order to clarify the purpose in requesting the records. If the patient request information about certain illnesses, injuries, or episodes only, the summary may be confined to those portion of the record. The summary must include for each injury, illness, or episode covered, any information in the medical record relative to the following

i. chief complaint or complaints, including pertinent history;
ii. findings from consultations or referrals to other health care providers;
iii. diagnosis, where this has been determined;
iv. treatment plan and regiment;
v. progress of the treatment;
vi. prognoses, including significant continuing problems or conditions;
vii. reports of pertinent diagnostic procedures and tests;
viii. discharge summaries
ix. objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests;
x. current medications prescribed, including dosage and any sensitivities or allergies to medications prescribed;

In some cases, the discharge summary which summarizes each episode of hospital care will meet these requirements, but it should not be used as the summary alternative without a careful review to be certain that it does, in fact, include all of the required information.

b. Allowable Time and Charges: Summaries must be provided within ten (10) working days after the written request is received. The provider may have thirty (30) calendar days in which to prepare the summary in two situations:

i. the record is lengthy (because there has been multiple admissions or the care has involved numerous tests or special care); or
ii. The patient has been discharged within ten (10) calendar days prior to the receipt of the request.
iii. The amount charged for the summary will be based on the amount of time spent by the physician and medical records staff in completing the record summary.
c. X-Rays and Tracings: Health care providers are not required to furnish copies of x-rays or tracings derived from electrocardiography, electroencephalography or electromyography, if the original x-rays or tracings are transmitted to another provider within fifteen (15) days after the receipt of a valid written request. Since such tracings are usually voluminous, it is suggested that the provider confer with the requesting party to determine whether copies, a reasonable charge which does not exceed actual cost may be made, without reference to the maximum charge specified for other copies [Section 25252(a)].

The law does not address the issue of the provider’s responsibility when the patient or representative declines to name another provider to receive x-rays or tracings and the provider does not have the equipment for making such copies. In some cases, it may be possible for the hospital to arrange to have these special items reproduced by another hospital or copy service in the area. If such an arrangement is not feasible, the provider’s good faith offer to transmit the originals to another provider probably meets the intent of the law and would be considered acceptable compliance.

Refer all requests for x-rays to the Radiology Department.

i. Patient Currently Residing at LHH
   - Allow patient to read his/her chart only if the attending physician is present to explain the medical information and to prevent any misunderstanding in reading the chart.
   - Pull chart and forward to attending physician.
   - If a copy/copies are requested.
   - Payment must be made by check or money order only.
   - Make a notation in the register.

ii. State Personnel
   - Use same procedure as for the Ombudsman.

iii. Attorney/Client
   - Arrange a date and time for the attorney/client to examine the record.
   - Pull the chart from either the file room or the unit and remove all miscellaneous correspondence, subpoena, etc.
   - One hour is the allowed time for review.
   - A Medical Record Technician must supervise the review.
   - If copies are requested the charge will be determined by the number of pages ($.25 per page) and $15. Copying fee.
     - Payment must be made by check only.
     - Make a notation in the register.
Revised: 2009/08/10
Original adoption: 1986/08
RELEASE OF INFORMATION

RESIDENT ACCESS TO HEALTH RECORDS:

POLICY:
The resident or resident’s legal representative shall have access to current Protected Health Information of the resident, **within five days** after submitting a written request (excluding weekends or holidays) according to Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and the California Health and Safety Code Section 123100 – 123149.5.

PURPOSE:
1. To allow residents the right review their protected health information.
2. To comply with current HIPAA Rules, California and Federal laws.

PROCEDURE:
1. Responding to Requests from In House Residents
   a. Monday to Friday, 9:00 a.m. to 4:00 p.m., except holidays: contact Health Information Services.

Per Health & Safety Code Section 123100: The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided.

Similarly, persons having responsibility for decisions regarding the health care of others should, in general, have access to information on the patient's condition and care. **It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.**

**Pursuant to Health & Safety Code Section 123110:** Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for
those records and upon payment of reasonable clerical costs incurred in locating and making the records available.

However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient's representative requesting the inspection, who may be accompanied by one other person of his or her choosing. (b) Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents ($0.25) per page or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The health care provider shall ensure that the copies are transmitted within 15 days after receiving the written request.

2. **Responding to Verbal Requests**

   Explain to resident or their legal representative that a written request is required. Use of the Hospital Form “Authorization for Use or Disclosure of Protected Health Information” is required. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be
Laguna Honda Health Information Services Policy & Procedures

Policy

Number: 13.05
Revised: August 24, 2015

returned to the sender. Access is given no later than five days of receipt of the request.

i. If a copy/copies are requested, the copies will be charged at the current rate per page.

ii. Payment must be made by check or money order only.

iii. Complete the required screens in the Release of Information module of the HIS Nuance Clintegrity System.

b. State Personnel

i. Use same procedure as for the Ombudsman.

c. Attorney/Client

i. Arrange a date and time for the attorney/client to examine the record.

ii. .

iii. Only authorized H.I.S. staff must supervise the review.

iv. If copies are requested, the charge will be determined by the number of copies at the current rate per page. Payment must be made by check only.

v. Complete the required screens in the Release of Information module of the HIS Nuance Clintegrity System.

3. **Processing Requests for Copies of Protected Health Information**

Upon receipt of an Authorization for use or disclosure of PHI:

a. Enter the requestor’s information into the Release of Information module of the HIS Nuance Clintegrity System.

b. Locate record

i. If record cannot be located after 48 hours, check the chart locator module to find out who was the last person the record was signed out to. Contact the individual to return the record to HIS.
ii. Place a copy of the Authorization for use or disclosure of PHI form in the resident’s medical record.

d. When payment is received

   i. Copy the requested pages of PHI.

   ii. Enter any remaining information into the HIS ROI module.

   iii. Mail copy by certified mail to requestor.

   iv. not permit,
RELEASE OF INFORMATION

PATIENT ACCESS TO HEALTH RECORDS:

POLICY:
The resident or resident’s legal representative shall have access to current Protected Health Information of the resident, within five days after submitting a written request (excluding weekends or holidays) according to the California Health and Safety Code Section 123100 – 123149.5.

PURPOSE:
1. To allow residents the right review their protected health information.
2. To comply with current HIPAA Rules, California and Federal laws.

PROCEDURE:
1. Responding to Requests from In House Residents

   Per Health & Safety Code Section 123100: The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided.

   Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care. It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.

   Pursuant to Health & Safety Code Section 123110:(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available.

   A. Monday to Friday, 9:00 a.m. to 4:00 p.m. except holidays: contact Health Information Services.
Laguna Honda Health Information Services Policy & Procedures

A. **Responding to Verbal Requests**

Explain to resident or their legal representative that a written request is required. Use of the Hospital Form “Authorization for Use or Disclosure of Protected Health Information” is required. Authorizations for use or disclosure of PHI received from other persons, providers, or agencies requesting information from DPH must contain all of the HIPAA-required elements. Inadequate authorizations should be returned to the sender. Access is given no later than five days of receipt of the request.

a. If a copy/copies are requested, the copies will be charged at the current rate per page.

b. Payment must be made by check or money order only.

c. Complete the required screens in the Release of Information module of the HIS Nuance Clinctegrity System.

B. **State Personnel**

a. Use same procedure as for the Ombudsman.

C. **Attorney/Client**

a. Arrange a date and time for the attorney/client to examine the record.

b. Only authorized H.I.S. staff must supervise the review.
c. If copies are requested, the charge will be determined by the number of copies at the current rate per page.

d. Payment must be made by check only.

e. Complete the required screens in the Release of Information module of the HIS Nuance Clinctegrity System.

B. Processing Requests for Copies of Protected Health Information

Upon receipt of an Authorization for use or disclosure of PHI:

A. Enter the requestor’s information into the Release of Information module of the HIS Nuance Clinctegrity System.

B. Locate record

1. If record cannot be located after 48 hours, check the chart locator module to find out who was the last person the record was signed out to. Contact the individual to return the record to HIS.

2. Place a copy of the Authorization for use or disclosure of PHI form in the resident’s medical record.

B. When payment is received

1. Copy the requested pages of PHI.
2. Enter any remaining information into the HIS ROI module.
3. Mail copy by certified mail to requestor.
4. not permit,
REVIEW OF DEVELOPMENTALLY DISABLED RESIDENTS’ RIGHTS

POLICY:

1. The registered nurse will perform a focused assessment for each developmentally disabled resident upon admission, relocation, and quarterly to assess for signs or symptoms of abuse or exploitation.

2. The Registered Nurse (RN), Licensed Vocational Nurse (LVN) and Certified Nursing Assistant (CNA), Patient Care Assistant (PCA) are responsible for observing and reporting signs and symptoms of abuse or exploitation.

PURPOSE:

To ensure that developmentally disabled residents are free from abuse or exploitation.

CHARACTERISTICS:

Developmentally disabled residents may be at greater risk for being abused or exploited than other residents because they may have a diminished ability to protect themselves and/or difficulty communicating their concerns or reporting problems.

PROCEDURE:

A. Assessment

When a developmentally disabled resident is admitted, the potential for sexual or other types of exploitation or abuse is to be individually evaluated and identified in the care plan.

B. Intervention

1. Upon admission, relocation, and every three months the licensed nurse is to assess developmentally disabled resident to identify any new problems and update the care plan accordingly.
   a. Residents unable to verbalize or communicate shall be observed for physical or behavioral symptoms of abuse or exploitation.
   b. Residents assessed to be capable of communication are to be formally interviewed in a private area.

2. Questions to use during the interview:
   a. Do you feel safe here at Laguna Honda?
   b. Is there anyone here whom you don't like? Why don't you like that person?
   c. Does anyone touch you in a way that makes you feel uncomfortable, frightened, or embarrassed?
   d. Is anyone here doing anything to you that you don't like, e.g., showing you private parts of their body?
   e. Is anyone asking to do anything you don't want to do, e.g., having you touch private parts of their body?
   f. Will you please tell me if any problems come up? Tell me if anyone does anything you don't think is right so I can help.
3. Suggestions to gain meaningful resident responses:
   a. Assure privacy for the interview.
   b. Take time to thoroughly explore resident's answers in an attempt to discover if there is anything which could be interpreted as abusive or improper.
   c. Rephrase questions several times as necessary to draw out the resident in discussion, e.g., if initial response is "Everything's OK, honey," rephrase your question and allow time for resident to focus on what is really happening with him/her.
   d. Resident's nonverbal behavior may be the response which leads you to suspect a problem to report. Try to get resident to talk about what he/she is feeling.

4. If abuse is reported by the patient or the suspicion of abuse or exploitation is indicated by physical symptoms or nonverbal behavior, an immediate investigation is to be implemented. Consult the nursing procedure, "Recognizing and Reporting Abuse" for detailed information.

C. Reporting

IMMEDIATELY report to Director of Nursing, the area supervisor, and the physician any responses which indicate an overt or suspected underlying problem and be prepared to investigate and follow up.

D. Documentation

1. Identify potential for abuse or sexual exploitation on the resident care plan upon admission.

2. Document each interview and patient's responses in the nurse's notes.

3. Record objective observations and assessment of resident condition including resident remarks as appropriate.

CROSS REFERENCES:

LH Policies and Procedures: 20-13 Abuse Protection Program: Prevention, Recognition, Reporting
LH Policies and Procedures: 20-18 Residents’ Rights

Revised: 1/2005, 1/2010
Reviewed: 12/2009
WOUND V.A.C (Vacuum Assisted Closure) PROTOCOL

Definitions:

1. Vacuum Assisted Closure (V.A.C) Therapy is an advanced wound healing therapy and technology coupled with microprocessor-controlled therapy units, specialized dressings, and 24/7 technical support.

2. V.A.C therapy is intended to create an environment that promotes wound healing by secondary or tertiary (delayed primary) intention by preparing the wound bed for closure, reducing edema, promoting granulation tissue formation and perfusion, and by removing exudates and infectious material.

Protocols:

1. For newly admitted resident with wound V.A.C., the physician at Laguna Honda Hospital (LHH) has a choice to continue wound V.A.C. treatment or send resident for consultation to Plastic Surgery for evaluation and treatment.

2. Wound V.A.C will be provided to residents based on an LHH physician order, whether wound V.A.C. is a continuation of outside treatment or initial treatment.

Indications for Wound V.A.C Therapy:

1. For residents who would benefit from -
   a. A sub-atmospheric (negative) pressure therapy for promotion of wound healing.
   b. Drainage and removal of infectious material or other fluids from wounds under the influence of continuous or intermittent sub atmospheric (negative) pressure.

2. Types of wounds indicated -
   a. Chronic wounds, including diabetic/pressure ulcers/venous insufficiency.
   b. Acute / traumatic wounds.
   c. Sub-acute wounds (non-healing surgical wounds).
   d. Dehisced wounds.
   e. Partial-thickness burns.
   f. Flaps.
   g. Grafts.

Contraindications for Wound V.A.C Therapy:

1. Residents with –
   a. grossly contaminated wounds
b. malignancy in the wound

c. untreated osteomyelitis

d. non-enteric and unexplored fistulas

e. necrotic tissue with eschar present

f. sensitivity to silver (VAC Granufoam silver dressing)

2. Do not place VAC Granufoam (black sponge) directly over exposed blood vessels, anastomotic sites, organs, or nerves. May use VersaFoam (white sponge) over exposed blood vessels or organs at base of wound with overlaying Granufoam.

Equipment and Supplies:

1. Licensed Nurse must specify the type of wound V.A.C. machine, at least one week supply of dressings, dressing kits, canisters, and other wound supplies needed from Materials Management (phone ext # 43337).

2. Other wound care supplies can be obtained by calling Central Supply or via intranet web order (http://in-sfgweb01/LHH/ MM/MM-main.htm), click on Pathways Horizon Supply Source.

   a. skin prep/skin barrier
   b. marker and scissors
   c. irrigation solution (normal saline)
   d. irrigation kit
   e. flashlight
   f. dressing supplies (see table)

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Kit VAC GranuFoam Dressing Bridge</td>
</tr>
<tr>
<td>1663</td>
<td>Kit VAC Drape only</td>
</tr>
<tr>
<td>7074785</td>
<td>Kit VAC Black Foam Dressing small Simplace</td>
</tr>
<tr>
<td>7074786</td>
<td>Kit VAC Black Foam Dressing medium Simplace</td>
</tr>
<tr>
<td>1668</td>
<td>Kit canister activac with gel</td>
</tr>
<tr>
<td>7074784</td>
<td>Kit VAC granufoam silver medium</td>
</tr>
<tr>
<td>2016</td>
<td>Kit VAC GranuFoam dressing medium</td>
</tr>
<tr>
<td>1660</td>
<td>Kit VAC Foam white</td>
</tr>
</tbody>
</table>

Wound Care using Wound V.A.C Therapy Treatment:

* The Wound V.A.C dressing should be changed every 48 hours or per physician order

1. Applying the dressing

   a. Wash hands and apply personal protective equipment.
   b. Gently remove the old wound V.A.C dressing.
   c. Irrigate the wound with normal saline or solution per physician order.
   d. Clean and dry periwound tissue and apply skin prep while covering the wound.
   e. Assess and measure depth, width, and length of wound cavity.
Wound V.A.C (Vacuum Assisted Closure) Protocol

LHH Nursing Policies and Procedures

f. Cut and shape the foam dressing to fill wound cavity completely ensuring that if multiple pieces of foam are required, all edges are in direct contact with each other for even distribution of negative pressure.
g. Ensure that foam dressing is within the edges of the wound cavity and NOT in contact with periwound tissue.
h. Size and trim the drape to cover the foam dressing as well as an additional 3-5 cm border of intact periwound tissue; save extra drape to be used to patch difficult areas and seal leaks.
i. Cut a 2 cm hole or quarter-size in the drape; it is not necessary to cut into the sponge.
j. Apply the T.R.A.C. Pad opening directly over the hole in the drape.
k. Attach dressing tubing to the suction canister tubing.
l. Label tubing with number of GranuFoam / WhiteFoam used, date, and licensed nurse initials.

2. Applying Wound V.A.C Device

a. Remove the canister from the sterile packaging and push in into the V.A.C device until it clicks into place.
b. Verify clamps on dressing tubing and canister is open.
c. Turn on the power button on the side of the V.A.C. device.
d. Adjust the V.A.C. device settings per the recommended guidelines for treating wound types.
e. Press “THERAPY ON/OFF” button to activate the negative pressure therapy.
f. Observe wound site for collapse and seal of the dressing
   i. If collapse and seal are not apparent, assess dressing for leak, which may create a whistling sound.
   ii. Often leaks are fixed by gently pressing around the drape and/or edges of the foam to better seal the drape.
   iii. Can also use excess drape to patch over leaks.

3. Removing the dressing

a. Raise the tubing connectors above the level of the device.
b. Tighten clamps on the dressing tubing and canister tubing and disconnect.
c. Press therapy on/off to deactivate the pump.
d. Gently remove drape from the skin.
e. Gently remove foam from wound.
   i. If foam dressing adheres to wound base, introduce normal saline into foam, let stand, and then remove.
f. Discard disposables in a bag.

Maintaining the Wound V.A.C Device:

1. The wound V.A.C. canister should be changed when full (device will alarm) or weekly.

2. Resident may be disconnected from unit for specific activities, but no more than 2 hours per 24-hour period.

3. To disconnect form the device:
   a. Close clamps on the tubing.
   b. Turn the device OFF.
   c. Disconnect the dressing tubing from canister tubing.
   d. Cover the ends of the tubing with gauze/clean glove or tubing cap and secure.

4. To re-connect to the device:
Wound V.A.C (Vacuum Assisted Closure) Protocol

LHH Nursing Policies and Procedures

4. a. Remove the gauze/clean glove from the ends of the tubing.
   b. Connect the tubing.
   c. Unclamp the clamps.
   d. Turn device ON and previous settings will resume.

Disconnecting from the Wound V.A.C Device:

1. Never leave a wound V.A.C dressing in place without active V.A.C therapy for more than 2 hours.
2. If therapy is off for more than 2 hours, remove old dressing, irrigate the wound, and apply wet to moist gauze until V.A.C therapy is restarted or evaluated by CNS or MD.
3. Notify physician or physician on-call (after hours) whenever V.A.C therapy has been stopped.

Trouble Shooting the Wound V.A.C Device:

1. Visually check the dressing every shift and as needed to ensure that the foam is firm and collapsed in the wound bed. If not:
   a. Make sure the display screen reads “THERAPY ON”.
   b. Make sure all clamps are open and tubing is not kinked.
   c. Identify air leaks and seal with drape.
   d. Visually check the V.A.C device is working and plugged in the electrical outlet every shift and as needed.
2. Call 1-800-275-4524 for assistance/questions (after hours, weekends, and holidays) 24-hours technical/clinical support.

Patient is discharge to Acute Hospital (Emergency or Hospital Admission):

1. Remove the old dressing and apply wet to moist gauze as well as DISCONNECT resident from the V.A.C. device prior to sending out of the facility.
2. DO NOT SEND the V.A.C Therapy device with the resident.
3. Licensed nurse from LHH will notify the receiving hospital (acute or emergency room) during hand-off report that resident’s wound V.A.C was discontinued prior to transfer or discharge.
4. Notify CNS and Materials Management if wound V.A.C. is discontinued to arrange equipment pick-up by KCI.

Documentation:

1. The following information will be included in the initial assessment and set-up:
   a. Wound location and size (L x W x D), including tunneling/undermining (**initial assessment and weekly wound measurement**)
   b. wound appearance (color, odor, presence of granulation tissue, necrosis)
   c. exudates, including color, amount, and odor
   d. type and number of foam sponges placed in the wound
   e. wound V.A.C device settings (amount of pressure and continuous vs. intermittent therapy)
   f. resident pain score
2. Assess and document at each dressing change the above information.

3. Nursing should assess and document wound site, exudates, and unit settings every 8 hours for:
   a. presence of negative pressure
   b. color, amount, and odor of exudates
   c. device settings (intermittent vs. continuous)
   d. patient pain score

Discharge Planning:

1. CNS/RN will coordinate with MD, social worker, or case manager if patient will need a wound V.A.C. at home.

2. MD will complete the KCI "Medical Necessity Document".

3. CNS/RN will fax the completed form to KCI and home health agency.

4. CNS/RN will provide patient education prior to patient discharge.

5. Return any unopened and unused dressing supplies to Materials Management.

ATTACHMENTS:

Attachment A: Types of Foam Dressing
Attachment B: Recommended Guidelines for Foam Use
Attachment C: Recommended Therapy Settings
Attachment D: Wound V.A.C Therapy Protocol Order

REFERENCES:

KCI V.A.C. Therapy Clinical Guidelines: A Reference source for clinicians (8/2010)
Wound V.A.C. KCI Protocol Vanderbilt University Medical Center (10/2004)

CROSS REFERENCES:

Nursing P&P K 1.0 Pressure Ulcer Prevention and Treatment
Nursing P&P K 2.0 Wound Assessment and Management

New Document: 02/11/2011
Reviewed: 03/24/2011
Approved: 03/24/2011
# Attachment A: Types of Foam Dressing

<table>
<thead>
<tr>
<th>V.A.C. GranuFoam Dressing (Black)</th>
<th>V.A.C. White Foam Dressing (Versa Foam)</th>
<th>V.A.C. GranuFoam Silver Dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black polyurethane foam dressing with reticulated (open) pores to help evenly distribute negative pressure across the wound bed, assisting in tissue granulation and aiding wound contraction</td>
<td>white polyvinyl alcohol foam</td>
<td>open-celled, reticulated polyurethane foam micro bonded with metallic silver</td>
</tr>
<tr>
<td>• dense, open-pore foam with a higher tensile strength for use in tunnels and undermining</td>
<td>• non-adherent; may aid in minimizing discomfort over fresh STSG (split thickness skin graft) or in situations where hypergranulation responses are likely</td>
<td>• during VAC therapy, exposure of the dressing to wound fluid results in oxidation of metallic silver to ionic silver, allowing the continuous, sustained release of silver ions that act as an effective barrier to bacterial penetration</td>
</tr>
<tr>
<td>• hydrophobic (moisture repelling), which enhances exudates removal</td>
<td>• hydrophilic (moisture retaining), packaged pre-moistened with sterile water</td>
<td></td>
</tr>
<tr>
<td>• available V.A.C. Simplace dressing Spiral GranuFoam small and medium)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• available GranuFoam Bridge dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• set therapy at 125 mmHg (continuous or per MD order)</td>
<td>• set therapy at 150 mmHg (continuous or per MD order)</td>
<td>• set therapy at 125 mmHg (continuous or per MD order)</td>
</tr>
</tbody>
</table>

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# Attachment B: Recommended Guidelines for Foam Use
### Wound V.A.C (Vacuum Assisted Closure) Protocol

#### LHH Nursing Policies and Procedures

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>V.A.C. GranuFoam (Black)</th>
<th>V.A.C. VersaFoam (White)</th>
<th>Either</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep; acute wounds with moderate granulation tissue</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full thickness pressure ulcers (stage 3 or 4)</td>
<td>X</td>
<td></td>
<td>May also use Bridge Dressing</td>
</tr>
<tr>
<td>Flaps</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful wounds</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial wounds</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tunneling/sinus tracts/undermining</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>Deep trauma wounds</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Wounds which require controlled growth of granulation tissue</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetic ulcers</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dry wounds</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Post graft placement (including bioengineered tissues)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Shallow chronic ulcers</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>Lower extremity ulcers, including venous leg ulcers and diabetic foot ulcers</td>
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<td></td>
<td>X May also use Bridge Dressing</td>
</tr>
<tr>
<td>Venous insufficiency ulcers</td>
<td></td>
<td></td>
<td>X May also use Bridge Dressing</td>
</tr>
<tr>
<td>Need for barrier to bacterial penetration</td>
<td>**Use V.A.C. GranuFoam Silver</td>
<td></td>
<td></td>
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**Attachment C: Recommended Therapy Settings**
## Wound V.A.C. Therapy Protocol Order

<table>
<thead>
<tr>
<th>Wound Characteristics</th>
<th>Continuous</th>
<th>Intermittent</th>
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<tbody>
<tr>
<td>Difficult dressing application</td>
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<td></td>
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<tr>
<td>Flaps</td>
<td></td>
<td>X</td>
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<tr>
<td>Highly exudating</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Grafts</td>
<td></td>
<td>X</td>
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<tr>
<td>Painful wounds</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tunnels of undermining</td>
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<td></td>
</tr>
<tr>
<td>Unstable structures</td>
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<td></td>
</tr>
<tr>
<td>Minimally exudating</td>
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</tr>
<tr>
<td>Large wounds</td>
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</tr>
<tr>
<td>Small wounds</td>
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<td>X</td>
</tr>
<tr>
<td>Stalled progress</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Attachment D: Wound V.A.C. Therapy Protocol Order
1. Start VAC Therapy with KCI ActiVac machine on __________________.

2. Run at 125mmHg continuous therapy or per physician order.

3. Treat the following wound (s): ______________________________.

4. Assess wound/VAC treatment every shift, including checking the therapy unit is working (THERAPY ON and plugged in). See documentation guidelines.

5. Measure wound (s) initially then weekly and document in wound assessment record.

6. At each dressing change, flush the wound with normal saline prior to new dressing application.

7. Pre medicate prior to dressing as ordered per physician.

8. Change VAC dressing: every Monday  Wednesday  Friday  or other: ________.

9. Use black foam dressing (granufoam, simplace, or bridge dressing) and canister.

10. May use white foam, if indicated, and set therapy at 150mmHg.

11. May use black foam (silver), if indicated

12. Change canister every 7 days or when full.

13. Activity/OOB per physician direction: ________________.

14. Replace old dressing (black foam) with wet to moist gauze if therapy is off more than 2 hours or if patient is sent out of the facility. DO NOT SEND THE WOUND V.A.C WITH THE PATIENT. Notify MD/CNS if treatment is interrupted / discontinued.

15. Call 1-800-275-4524 (24/7) technical / clinical support for questions / problems.