

**Annual Departmental and Hospital-wide Policies and Procedures Review  
Submitted to the Joint Conference Committee (JCC) for Approval on  
September 8, 2015**

The annual Laguna Honda Hospital (LHH) policy and procedure review meeting was held on August 31, 2015 to review hospital-wide and departmental policies and procedures that were newly developed, revised or deleted over the past year. This includes policies and procedures that were previously submitted and approved by the JCC on 11/25/2014, 1/13/2015, 3/10/2015, 3/10/2015, 5/12/2015 and 7/14/2015.

Policy and Procedure changes that have not been previously submitted and approved by the JCC are listed and summarized below:

**Hospital-wide Policies and Procedures**

New Policies

<u>Policies</u>	<u>Comments</u>
LHHPP 90-04 Parking on the Laguna Honda Hospital Campus	Created to provide rules and regulations governing parking on LHH campus for visitor, employees, and volunteers.

Revised Policies

<u>Policies</u>	<u>Comments</u>
LHHPP 21-02 Transmission of Confidential Medical Information via Fax	Incorporated the location of PHI cover sheet and clarification in 2b. A bullet was added to iv regarding information and cover sheet for EMTs. Procedures 3b and 3bi were deleted due to redundancy of previous statements and authorization is not obtained in an emergency. Procedure 3bii was deleted since the restriction for protected categories is not necessary when the information is part of the general medical record. Procedure 5 was deleted and procedure 6 modified for process clarification.
LHHPP 21-04 HIPAA Compliance	Incorporated several clarifications to match better with DPH policies and to clarify LHH-related processes.
LHHPP 21-05 Medical Record Documentation	Changed "LCR" to "Electronic Health Record". Addition of SFDPH scribe policy for San Francisco Health Network electronic health record.
LHHPP 22-08 Threats of Violence to Residents by External Party	Change in procedure to call Sheriff's Office at 4-2319 for assistance instead of Operator (4-2999).
LHHPP 24-08 Off-Campus Appointments or Activities	Changes in policy statement #1 stating that escorts will be provided with necessary training & information for resident's safety. Additional information regarding escorts using taxi service, under procedure 2e, where to get and how to use taxi vouchers and MUNI token, see Procedure Section #2-e. Verbiage change in procedure section 3 regarding requesting for nursing staff escort.
LHHPP 24-09 Ambulance Call	The inclusion of LHH contracted ambulance providers and types of services provided. Clarification around the purpose of the policy.

LHHPP 29-02 Resident as Photography or Interview Subject	Updated "resident" to "resident/ decision maker" throughout policy. Incorporated where authorization can be found and where it must be filed. Deleted procedures 4-6.
LHHPP 60-04 Unusual Occurrences	Clarification given regarding the process of completing and submitting an unusual occurrence report.
LHHPP 60-07 Licensing and Certification Visits	Three procedures (6-8) were incorporated to provide clarification surrounding materials to be provided to L & C surveyors.
LHHPP 70-01 Emergency Preparedness Committee	Frequency of meetings was updated.
LHHPP 70-02 Emergency Preparedness	Minor changes including removal of the reference to B-102 as the command center. The sections on emergency supplies were combined into one policy, as oppose to two. Lastly, the number of individuals a 7-day food supply must be available for was updated.
LHHPP 72-01 Infection Control Manual	The following terminology contained in the Infection Control Manual under LHHPP File: 72-01 will be revised and updated as follows: <ol style="list-style-type: none"> <li>1. "Body substance precautions" will be changed to "standard precautions"</li> <li>2. "Low respiratory precautions" will be changed to "droplet precautions"</li> <li>3. "High respiratory precautions" will be changed to "airborne precautions"</li> <li>4. "Alcohol based hand gel" will be changed to "alcohol based hand rub"</li> </ol>
LHHPP 75-02 Public Access and Night Security	Addition of requirement to have identification visible at all times. Procedure surrounding suspicious activity updated to provide more thorough instruction.
LHHPP 75-03 Disorderly or Disruptive Visitors	Addition of a procedure to enforce visitor check in with Sheriff's staff. Change in procedure to call Sheriff's Office at 4-2319 and protocol for caller.
LHHPP 75-04 Calls for Sheriff's Assistance	Change in procedure to call Sheriff's Office at 4-2319 for assistance instead of Operator (4-2999). Title change and edits made throughout.
LHHPP 75-06 Dr. Grey	Procedure updated to clarify information needed from caller.
LHHPP 76-03 Animal Control	Edits were made to make the policy and procedures more concise. References were incorporated.
LHHPP 84-01 Student Affiliations	Deleted statement requiring signature card – obsolete process per Debra Darden; added location of electronic student.

#### Deleted Policies

<u>Policies</u>	<u>Comments</u>
LHHPP 72-01 C3 Disposable Medical Supplies	For deletion because covered in LHHPP 31-03 Clinical Product and Device Evaluation.

**Department: Admissions & Eligibility**New Policies

<u>Policies</u>	<u>Comments</u>
04-18 Invision Race Field	New Invision fields.

**Department: Central Supply**New Policies

<u>Policies</u>	<u>Comments</u>
F-05 Central Supply Storeroom Inventory Security	Controller's audit recommendation.

**Department: Clinical Laboratory Services**

*No changes were made.*

**Department: Clinical Nutrition Services & Diet Manual**Revised Policies

<u>Policies</u>	<u>Comments</u>
Diet Manual – Contact Information for Clinical Staff	Current RD pager, phone and neighborhood assignment list updated.

**Department: Environmental Services**New Policies

<u>Policies</u>	<u>Comments</u>
XVIV. Pressure Washer Cleaning	Incorporated to department policies and procedures.
XX. Cubicle Curtain & Drape Replacement	Incorporated to department policies and procedures.
XXI. Rag Out Procedures	Incorporated to department policies and procedures.
XXII. EVS Temporary Services	Incorporated to department policies and procedures.

Revised Policies

<u>Policies</u>	<u>Comments</u>
III. EVS Organization Chart	Update position counts and titles.
XIV. Mail Room Procedure	Edit item F. Delivery Procedure. Addition of item G. to include the policy for distributing Parcels and Packages received from USPS.
XVI. Ice Machine & Refrigerator Cleaning	Revised to update the August 2013 procedures for the 3 Bucket System.

**Department: Facility Services**Revised Policies

<u>Policies</u>	<u>Comments</u>
DP-31 Standard Precautions	Integrated existing DP-31 P&P with the Infection Control Manual Policy E15 and renamed P&P DP-31
LS-5 Grounds Policy	Minor grammatical changes.
LS-6 Construction/Renovation Standards	Integrated existing LS-6 P&P with the Infection Control Manual Policy F1 and renamed P&P LS-6

**Department: Health Information Services**New Policies

<u>Policies</u>	<u>Comments</u>
10.07 Processing External Quality Assurance (EQA) Reports	A daily function in HIS Transcriptionists: research and correct incomplete transcribed reports from vendor.

Revised Policies

<u>Policies</u>	<u>Comments</u>
1.01 Scope of Services	Updated terms and one responsibility.
1.04 Patient vs Resident Terminology	Updated verbiage.
2.02 Vacation Requests	Updated verbiage.
2.04 Performance Evaluations	Updated terms and process.
2.05 Continued Education and Training	Updated terms and process.
4.01 Content and Sequence Medical Rec Forms	Updated terms and process.
4.03 Admission Diagnosis	Updated terms and process.
7.02 Abstract Procedure	Updated process and systems.
7.03 Completion of Medical Records	Updated process and systems.
7.05 Acute vs SNF Records	Updated terms and process.
8.01 MS-DRG Assignment	Updated terms and process.
8.02 MAC Reviews	Updated terms and process.
10.03 Format: Transcription Services	Updated terms and process.
10.04 Production Statistics: Transcription Services	Updated terms and process.
10.05 Work Standards/Productivity	Updated process.
10.06 CQI: Continuous Quality Improvement	Updated terms, systems, and process.
12.01 Retention and Destruction	Updated process, terms, and added HIPAA.

Deleted Policies

<u>Policies</u>	<u>Comments</u>
03.01 Guideline for Entries	HIS employees don't make entries = N/A to HIS.
03.03 Charting Errors & Omissions	HIS employees don't make entries = N/A to HIS.
05.01, 05.02, 05.03 Patient/Resident ID System	HIS employees don't make entries = N/A to HIS.
10.02 Transcription distribution	Function no longer applies since '09.
11.01 Physician Service Charges	Function not performed by HIS: N/A.
13.02 Release of Medical Information w/ Patient Authorization	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
13.03 Release of Medical Information w/out Patient Authorization	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
13.07 Release of Mental Health Records	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
13.08 Release of alcohol & Drug Abuse Records	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
13.09 HIV Anti-body Test Results	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
13.10 Release of Medical Information of Minor Patients	Inclusive of 13.01 (NOW in line w/DPH P&P and HIPAA compliant).
14.01 Medical Records Committee Review	Non-existent, we attend the meeting no Reviews conducted as part of the mtg.
15.01 Advance Directives	HIS does not provide patients with this; N/A to HIS.
17.01 Clinical Pertinence	Non-existent; Not done since 2009.

**Department: Materials Management**

*No changes were made.*

**Department: Medical Staff**

*No changes were made.*

**Department: Nursing Services**Revised Policies

<u>Policies</u>	<u>Comments</u>
NPP A 5.0 Nursing Education Affiliations (Student Placements) Attachment 1	Verbiage change in policy statement, added each clinical instructor will not exceed ten (10) students per clinical shift. Verbiage and formatting changes in the procedure section A-7-9, section B, C, D, and E which details the responsibilities of the clinical instructors, students, and

	<p>affiliation coordinator. A Student-Resident Assignment form was developed to track students assigned to resident and will be kept in CNA/PCA binder. Added cross-references.</p> <p><u>Attachment 1</u>: Student-Resident Assignment Clinical Rotation Form (new).</p>
<p>NPP C3.0 Documentation of Resident Status/Care by the Licensed Nurse Appendix 1 Appendix 2</p>	<p><u>Title</u>: Added resident “status” in the title of the policy. Policy: Simplify verbiage in policy statement to reflect LN responsibility in recording in written &amp; electronic documentation.</p> <p><u>Procedure</u>:</p> <ol style="list-style-type: none"> <li>1. Progress notes must reflect nursing assessment, planning, intervention, outcome, and evaluation and be completed in a timely manner. Written documentation must be legible with LN name &amp; title.</li> <li>2. Frequency of Nursing Documentation: <ol style="list-style-type: none"> <li>a. No change. Current practice minimum documentation of once per shift x 72 hours or until condition is stable.</li> <li>b. Skilled Nursing Neighborhood – re-title the section of section 2-c to “unanticipated change in resident condition or potential/actual decline”. Examples of changes in conditions were expanded.</li> </ol> </li> <li>3. Deleted section for flagging of the chart. Practice varies.</li> <li>4. Obtaining of nursing forms &amp; medical records were moved to Appendix 1.</li> <li>5. NPP C 3.1 Guideline for Documenting Resident Care by the Licensed Nurse was deleted and becomes Appendix 2 and renaming the title to Charting/Documentation/Reporting Expectations.</li> <li>6. Focused Progress Note Stamp will no longer be used. However, the LN will titled the progress notes as “Focused Progress Note” (FPN) when documenting a resident condition or incident requiring focused assessment, immediate action, and follow-up is identifies. FPN must have accurate description of the situation, immediate actions, modifying care plan, and facilitating prompt follow up. FPN will have date, time, &amp; LN signature.</li> </ol> <p><u>Appendix 1</u>: Obtaining Nursing Forms, Medical Records, and Chart Order <u>Appendix 2</u>: Charting/Documentation/Reporting Expectations</p>
<p>NPP D2 2.0 Bathing Alternatives/ Bed Bath Appendix 1</p>	<p>Verbiage change in policy statements, simplified the purpose statement. Simplify verbiage on procedure A. Alternative bathing &amp; hair washing techniques was moved to appendix 1.</p> <p><u>Appendix 1</u>: Alternative Bathing and Hair Washing Techniques</p>
<p>NPP D 8.0 Post-Mortem Care Attachment 1</p>	<p><u>Changes includes changes in policy statements</u>:</p> <ul style="list-style-type: none"> <li>• #2 death notification is completed by the physician</li> <li>• # 3 the deceased body will be transported to the LHH morgue during business hours (0800 until 2300)</li> </ul> <p><u>Changes in procedure sections</u>:</p> <ul style="list-style-type: none"> <li>• B-1 persons to notify</li> </ul>

	<ul style="list-style-type: none"> <li>• C-1 attentive to cultural/religious preferences (Attachment 1)</li> <li>• C-3 wedding ring or other jewelry store in the NM office.</li> <li>• D-3 if the deceased body is in an open double or triple room &amp; has roommates, relocate deceased body to a private room</li> <li>• E-5 deceased body will remain in the room from 2300 to 0800, if needed to be transported to morgue, contact Nursing Office. Nursing Office assigns 2-3 staff member from other unit to assist with transportation.</li> <li>• F-5 &amp; 6 additional information regarding resident with “Pre-Need” or prior funeral arrangement. Nursing or SW will place the “Pre-Need” form in the Advanced Directives section and will document in the front card RCP under preferences.</li> <li>• G-2 resident’s property will be boxed, labelled, and stored in the designated storage room in K-5.</li> </ul> <p>Updated cross-references.  <u>Attachment 1</u>: Understanding Cultural &amp; Religious Preferences for Care of the Dying &amp; the Deceased – sample of questions to assist RCT to understand resident cultural &amp; religious preferences during death.</p>
NPP G 6.0 Behavioral Risk Assessment and Care Planning Attachment 1 Attachment 2 Attachment 3	<p>Re-titled to Behavioral Risk Assessment and Care Planning. Minor change in verbiage with policy statement #3 to include behavioral risk assessment when resident is transfer to another neighborhood. Minor verbiage changes in procedure section. Organized formatting and editing sections in developing behavioral risk care plans in Attachment 1.</p> <p><u>Attachment 1</u>: Guidelines to Develop Behavioral Risk Care Plans.  <u>Attachment 2</u>: Nursing Assessment Behavioral Risk (MR 340) – not included in the email attachment.  <u>Attachment 3</u>: Behavioral Monitoring Records: Code Sheet (MR 330A) and Log Sheet (MR 330B) – not included in the email attachment.</p>
NPP J 2.5 Monitoring Behavior and the Effects of psychoactive Medications	<p>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.</p>

### Deleted Policies

<u>Policies</u>	<u>Comments</u>
NPP C 3.1 Guidelines for Documenting Resident Care by the Licensed Nurse	This was changed as Appendix 2 and retitled Charting/Documentation/Reporting Expectations.

### **Department: Nutrition Services**

*No changes were made.*

**Department: Outpatient Clinics***No changes were made.***Department: Pharmacy Services**New Policies

<u>Policies</u>	<u>Comments</u>
01.09.00 Annual Physical Inventory Count	Procedures to assure fiscal year-end inventory count is scheduled and performed in accordance with LHH Accounting P&P.
02.06.00 Drug Supply Chain Security Act Transaction Data	Comply with new regulation safeguarding the United States drug supply.

Revised Policies

<u>Policies</u>	<u>Comments</u>
05.01.00 Formulary and Non-Formulary Medication Requests	Change formulary to on line format currently in use and remove requirement for a six month renewal of non-formulary drugs.
05.03.00 Therapeutic Interchange and Generic Substitution	Updated to reflect the interchange list is maintained by pharmacy and posted on the intranet.
06.01.00 Medication Regimen Review	Documentation of the initial pharmacist admission medication review and reconciliation is documented in the EHR.

**Department: Radiology***No changes were made.***Department: Rehabilitation Services**Revised Policies

<u>Policies</u>	<u>Comments</u>
80-04 Scope of Physical Therapy Services	Name change for clarity to Scope of Physical Therapy Services.
90-03 Scope of Speech Therapy Services	Name change for clarity to Scope of Speech Therapy Services.

**Department: Respiratory Services***No changes were made.*



**Department: Social Services**New Policies

<u>Policies</u>	<u>Comments</u>
7.19 Burial and End of Life Care Arrangements	Social Workers will document burial and pre-need arrangements on the initial psychosocial assessment and relay information to A&E and Nursing department. If no plans made, social workers will bring up with residents/family on a quarterly basis and especially as a resident's condition declines. Information will be reviewed with receiving social worker if resident transfers to another unit during their stay.

**Department: Spiritual Care**Revised Policies

<u>Policies</u>	<u>Comments</u>
C3.0 SCD Spiritual Care Referrals	Information on Emergency Contacts updated.

**Department: Volunteer Services**New Policies

<u>Policies</u>	<u>Comments</u>
A 1.0 Recruitment Process Life Cycle	This is a new P & P as we combined four P & P's to create this as it captures the entire process of a volunteer's experience at LHH.
A 2.0 Volunteer Fingerprinting	This is a new P & P as we just implemented the process this year to manage the risk to the reputation of LHH and the well – being of the residents served.

Revised Policies

<u>Policies</u>	<u>Comments</u>
A 3.0 Volunteer Orientation	New policy number.
A 4.0 Infection Control	Information about documentation was omitted. New associated number.
A 5.0 Volunteer Inquiry	Services for treatment from the OHS and cost of a medical evaluation being absorbed by DPH was deleted. Protocol of a volunteer was changed and filling out a UO was added. Information regarding worker's compensation was also removed. New associated number.
A 6.0 Record Keeping	Minor verbiage was changed. New associated number.
A 7.0 In-Kind Donations	Minor edits were made and information about community organizations and their contact information was deleted. New associated number.
A 8.0 Clothing Room	Information regarding accessing the clothing room was added for all neighborhood staff to have a badge and key to visit the clothing room when necessary. New associated number.
A 9.0 Resident Library	Minor edits were made to reflect recent changes with the internet

	access for residents. New associated number.
A 10.0 Holiday Gifts Program	Acronyms were deleted (e.g. VSD) and "Volunteer Services Department" was added instead. New associated number.

Deleted Policies

<u>Policies</u>	<u>Comments</u>
A 1.0 Volunteer Recruitment	All policies were deleted and combined to create on policy titled, "Recruitment Life Cycle."
A 3.0 Volunteer Placement	
A 4.0 Encouragement and Retention	

**Department: Wellness & Activity Therapy**New Policies

<u>Policies</u>	<u>Comments</u>
P6 Volunteer Placement Program	New process, now have point of contact.

Revised Policies

<u>Policies</u>	<u>Comments</u>
A7. Neighborhood Money/Shopping Time	Changes made requested by controller's office.
A12. Emergency Response Plan	To better describe procedure.
D2. Tracking of Resident Participation	More detail added to process.

Deleted Policies

<u>Policies</u>	<u>Comments</u>
D3. Medical Record Deficiency Resolution	No longer receive notices from HIS.
P2. Community Outing Program	Modified to Hospital Wide Policy.

## **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.

### **PROCEDURES:**

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:
      1. LHH Employee Parking Permit Application.
      2. 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
  - 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
    - 1. 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)
    - 1. 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

- i. 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).
  - ii. If an individual wishes to contest a parking ticket he/she may follow the procedures noted on the back of the ticket.
  - iii. 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.
- 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:
    1. any portion is not visible or legible,
    2. any portion has been altered,
    3. the appropriate fee has not been paid,
    4. it has been lost, stolen, or cancelled (it must be reported immediately).
  - ii. 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.
  - iii. Permit holders agree to abide by LHH campus and DPT parking policies. Failure to do so may result in the loss of parking privileges.
  - iv. Employees who violate the LHH parking policy may face progressive disciplinary action, including suspension or revocation of parking permit
- 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:
    1. Voluntary separation

2. Dismissal/termination of employment
  3. 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 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)

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 Hmelo in the Administration Office or fax to 415-759-2374. Please allow up to a week before your name will appear on the waitlist.

**SHIFT:**      **DAY**       **NIGHT**       **AM**

Request Date:	DSW or EMPLOYEE #:	
Last Name:	First Name:	Home Phone:
Department:	Location:	Ext.
Pager:	Personal E-Mail:	

Vehicle Information				
Vehicle 1	Make: (i.e. Ford, Honda)	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 2	Make: (i.e. Ford, Honda)	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 3	Make: (i.e. Ford, Honda)	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 4	Make: (i.e. Ford, Honda)	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		

-----Internal Use – Do Not Write Below-----

Permit #:	Tag Color:	Date Issued:	Initials:
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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**



CITY AND COUNTY OF SAN FRANCISCO  
 PAYROLL/PERSONNEL SERVICES DIVISION

**Payroll Deduction Authorization/Cancellation Form**

If no response after two pay periods, call PPSD. Do not resubmit.

<b>PPSD use only</b>

NEW AUTHORIZATION     CHANGE AUTHORIZATION     CANCELLATION

EFFECTIVE DATE		
MM	DD	YY
/	/	

EMPLOYEE ID	RECORD #	LAST	EMPLOYEE NAME FIRST	M.I.	DEPT. ID	DEPT. NAME	JOB CLASS

**INDICATE THE DEDUCTION NAME AND DEDUCTION AMOUNT:**

✓	DEDUCTION NAME	DEDUCTION CODE	MONTHLY DEDUCTION AMOUNT
	PARKING FEE FOR DPH – LAGUNA HONDA HOSPITAL	PRK001	\$
	PARKING FEE FOR LHH MOTORCYCLE/SCOOTER ONLY	PRK010	\$
			\$
			\$
			\$

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., 8<sup>th</sup> 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

**UNION / AGENCY / DEPARTMENT USE ONLY**

AUTHORIZED BY \_\_\_\_\_ PHONE \_\_\_\_\_ DATE \_\_\_\_\_  
 SIGNATURE

DO NOT WRITE BELOW THIS LINE

**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:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> METER PAID / MALFUNCTION     | <input type="checkbox"/> CURB PAINT FADED   | <input type="checkbox"/> MISSING OR OBSCURED SIGN            |
| <input type="checkbox"/> STOLEN VEHICLE               | <input type="checkbox"/> SOLD/NOT OWNED YET | <input type="checkbox"/> VALID PERMIT / DP DISPLAYED         |
| <input type="checkbox"/> COMPLIANCE / FIX IT CITATION | <input type="checkbox"/> DISCLAIMER         | <input type="checkbox"/> TRANSIT AND OTHER, EXPLAIN DETAILS: |

VEH PLATE NO: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

CITATION NUMBER(S):

ADDRESS: \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

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: 415.701.3000 | Fax: 415.701.5200 | www.sfmta.com



## **TRANSMISSION OF CONFIDENTIAL MEDICAL INFORMATION VIA FACSIMILE (FAX)**

### **POLICY:**

Use of facsimile (fax) transmission to provide resident/patient health information records within Laguna Honda or to any agencies, facilities, or persons outside of Laguna Honda Hospital shall be consistent with Federal and State privacy regulations.

### **PURPOSE:**

To maintain resident/patient confidentiality and health information record integrity.

### **REGULATIONS AND RESTRICTIONS:**

The disclosure of health information from the medical record is strictly protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal privacy laws. Unauthorized release of medical record information may result in administrative, civil and criminal sanctions, including fines and imprisonment.

### **PROCEDURE:**

- 1. 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”, available on the Laguna Honda Intranet (under LHH forms, [section “P”](#)).
- 2. Intra-Hospital Transmission**
  - a. Physician orders (e.g. for medication, labs, x-ray, therapy, nutrition, etc.) and other clinical documents such as rehabilitation referrals and transportation prescriptions may be transmitted to the appropriate hospital departments, pursuant to DPH policies and procedures.
  - b. Patient/resident health records may be transmitted to the Quality Management Department for their designated areas of responsibilities [\(i.e. from neighborhoods\)](#).
- 3. Transmission Off Site to Agencies, Facilities, or Persons Outside of Laguna Honda Hospital (Third Parties)**
  - a. Fax transmission of resident/patient health information records to third parties is restricted to:
    - i. Health Information Services personnel, pursuant to the policies and procedures established by the Health Information Services Department;

- ii. Utilization Management nursing staff to the Medi-Cal, MediCare Managed Care or other Insurance payer, pursuant to the protocols' established by the Department of Utilization Management; and
- iii. Quality Management authorized staff to the California Department of Public Health

iv. Clinicians sending requested information for off-site healthcare appointments, such as copies of the current Medication Administration Record (MAR).

- Copies of records for emergency room visits are handed to the EMT with a PHI cover sheet on top but may be faxed if requested by the emergency room provider.

iv.v. Admissions and Eligibility staff who fax transportation prescriptions to transportation companies for services.

v.vi. Social Services who occasionally fax information during Medical Records off hours when a delay in faxing may result in a delay in service that could negatively impact a resident. In such cases, Social Services staff must inform medical records by phone or email.

~~b. When there is a medical emergency and Health Information Services Department is closed, the attending physician or licensed nurse may transmit resident/patient health information via fax to other health care providers under the following conditions:~~

~~i. As time and circumstances allow, the Authorization to Disclose Health information by the resident/patient or surrogate decision maker is verified prior to transmission.~~

~~ii. Transmitted documents do not include information reflecting the following conditions or diagnoses:~~

- ~~• AIDS/HIV related conditions~~
- ~~• Sexually transmitted diseases~~
- ~~• Substance use/abuse~~
- ~~• Mental Illness~~

e.b. Hospital staff not specifically listed in section A3(a) or (b) above (e.g., medicine, social services, rehabilitation, etc.) who receive requests for fax transmission of resident/patient health information from vendors and other health care providers (e.g., home care agencies, other facilities) shall forward these requests to the Health Information Services department for appropriate action.

#### 4. Facsimile Transmission Process

- a. Attach a completed "Protected Health Information Cover Sheet Required for Fax Transmissions, Interoffice Mail, and U.S. Mail & Other Mail", available electronically under LHH Forms.
- b. Assure that the document and resident identification is clearly readable.
- c. Verify the fax number of the intended recipient.
- d. Remove all staples, paper clips, and adhesive tape from the document.
- e. After transmitting, review the transmission verification notification to assure that the correct number of pages was transmitted to the correct fax number.

~~5. Staple together the cover sheet, transmission verification, and copy of the documents transmitted and place in the Health Information Services (HIS) in-box on the unit for filing in the thinned resident chart on the neighborhood or directly in the chart behind the "miscellaneous" tab.~~

#### 6.5. In the event of a misdirected fax transmission

- i. A recipient of a misdirected fax transmission is directed by instructions on the fax cover sheet to notify the sender.
- ~~i.ii.~~ The sender of a misdirected transmission should~~hall~~ will notify the inadvertent recipient, ~~(via fax or telephone)~~ as soon as they are aware, of the error, and instruct the recipient ~~either to redirect or to destroy~~ the transmitted document(s) ~~it~~ by shredding.
- ~~ii. A recipient of a misdirected transmission will notify the sender of the misdirection and should will either redirect or destroy it by shredding, as instructed by the sender.~~
- iii. Any employee who knows of, suspects, or has a question regarding a possible violation of privacy is obligated to report this information to their immediate supervisor and/ or the Privacy Officer at the time of discovery. Supervisors receiving such reports must immediately notify the Privacy Officer.

#### **ATTACHMENT:**

None

#### **REFERENCE:**

LHHPP 21-01 Medical Records Information: Confidentiality and Release

LHHPP 21-04 HIPAA Privacy Policy

LHHPP 24-08 Off Campus Appointments or Activities

DPHPP HIPAA compliance – DPH Privacy Policy

DPHPP Secured Delivery of Protected Health Information through Interoffice Mail, US Mail, Other Mail, and by Fax Transmission

DPHPP HIPAA Compliance-Reporting of Unlawful or Unauthorized Access of Protected Health Information

| File: 21-02 Transmission of Confidential Medical Information Via Facsimile Revised September 8, 2015

| Revised: 98/11/16, 10/03/30, 11/09/27, 13/05/28, 13/09/24, 15/09/08 (Year/Month/Day)  
Original adoption: 98/11/16

## HIPAA COMPLIANCE

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~LHH~~ ~~aguna Honda~~) implements procedures that comply with the San Francisco Department of Public Health (DPH) "HIPAA Compliance: Privacy Policy", which adopts ~~the privacy rules set forth in~~ the Privacy Rules set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related federal and state confidentiality laws.

[LHH staff are responsible for complying with both LHH and DPH Privacy and Data Security policies \(Appendix A\).](#)

### PURPOSE:

The purpose of this policy is to provide guidance to ~~LHH~~ ~~aguna Honda~~ employees by clarifying how the basic requirements for protecting the confidentiality of medical information apply to ~~LHH~~ ~~aguna Honda~~ work processes.

### DEFINITION:

Protected Health Information, or "PHI", covers information relating to an individual's health, the care received and/or payment for services, including demographic data. It includes all information in any media related to the individual's health care that can be individually identified as belonging to a particular person.

### PROCEDURE:

#### 1. Residents notification of HIPAA Privacy Practices

- a. [LHH is required to provide residents](#) ~~Residents are provided~~ with the "DPH Notice of HIPAA Privacy Practices" upon admission.
- b. [Staff are to request the resident/ decision maker to sign the acknowledgment of receipt, however the resident has the right to refuse to sign under privacy laws.](#)
- c. [The signed acknowledgement is kept in the medical record.](#)
- d. [The date the notice was provided is entered in the ~~Lifetime Clinical Record \(LCR\)~~ ~~electronic health record~~.](#)
- e. [A copy of the notice is offered to the resident/ decision maker.](#)
- a. ~~and the signed acknowledgement is kept in the medical record.~~
- b. ~~Exception: The notice does not need to be provided or signed~~
- c.f. ~~Exception: The notice does not need to be signed~~ again if the ~~Lifetime Clinical Record (LCR)~~ ~~LCRelectronic health record~~ indicates a date and user identification verifying that the HIPAA notice was previously [signed provided](#) (i.e. for most residents who were admitted from San Francisco General Hospital).

#### 2. Posting of ~~PHI~~ [the DPH Notice of Privacy Practices](#) Notices



a. Providers, such as hospitals and clinics, are required to post the Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect residents to be able to read the notice.

~~a.b. LHH posts notices summaries s are posted~~ in the main lobby of the Pavilion building outside Admissions and Eligibility, Outpatient Clinic entry area waiting room, and the entry area of each neighborhood and includes the full notice in the survey binders available to residents., ~~main lobby of the old Administration building and in the Social Services department on G5.~~

~~b.c. DPH notices regarding HIPAA Privacy Practices~~ are available in English, Chinese, Russian, Spanish, Tagalog and Vietnamese.

~~e.d. Most Each~~ neighborhoods haves a notice posted in English. The exceptions are neighborhoods on N4 and N5 with posted have notices in Spanish and Chinese, respectively, as these are the most commonly used languages by the residents.

### 3. Social Media

Social media includes items such as blogs, podcasts, websites, ~~discussion forums~~discussion forums, social networks (e.g., Facebook, YouTube, Twitter, LinkedIn or hyperlinks from email).

a. Resident information must not be disclosed through social media of any kind without permission of the resident, guardian or conservator as described in LHHPP 29-02 Resident As Photography Or Interview Subject (form MR802 available from the Materials Management electronic ordering system on the LHH intranet).

b. Unauthorized Disclosure of protected information is a violation of the Health Insurance Portability and Accountability Act (HIPAA), ~~and/or~~ DPH policy and or LHH Laguna Honda policy. Protected information includes:

i. **Protected Health Information (PHI)** – Any identifiable medical information (verbal~~oral~~, written or electronic) about the patient's physical or mental health, the receipt of health care, or payment for that care.

ii. **Patient Identifiable Information (PII)** – Any individually identifiable information regarding patient/resident name, address, Social Security number, account number, security code, driver's license number, financial or credit account numbers, phone numbers, and Internet domain addresses, and other personal identifiers.

- 
- iii. Posting or hyperlinking photos, images, video, recordings, text, or other information that could reasonably lead to the identification of a patient/resident.
  - c. DPH issued-email addresses may not be used for personal access to social networking sites nor may you use a DPH issued-email address for personal use on social networking sites.
  - d. Staff members should consult with their supervisor if they are unsure whether any DPH or ~~LHHaguna Honda~~-related information or patient information is confidential.
  - e. Transparency: If staff members identify their affiliation with DPH or ~~LHH Laguna Honda~~ in any online social medium or network or if their affiliation with DPH or ~~LHHaguna Honda~~ could be presumed, they must make it clear that they are not speaking for DPH or ~~LHH aguna Honda~~ by using this statement: ***“The views expressed here are my own and not those of my employer.”***
  - f. Any social media conversation, whether public or private, may be subject to public disclosure.
4. Training of Staff, Volunteers and Affiliating Students Regarding PHI
- a. All staff, students, and volunteers who are assigned to transport medical records receive initial HIPAA training utilizing the DPH curriculum. In addition, annual re-training is provided to all staff through the Department of Education and Training. Managers are responsible for assuring compliance.
    - i. All volunteers receive orientation to HIPAA Privacy Practices with essential points from the DPH curriculum.
  - b. All ~~LHHaguna Honda~~ staff, volunteers and affiliating students must comply with the DPH confidentiality agreement and sign the DPH User Confidentiality, Security and Electronic Signature Agreement Form (available on the LHH Intranet under “LHH Forms”, section “I”).
  - c. Signed forms are filed in the employee's personnel record in Human Resources, in the Volunteer Coordinators office, or in the affiliating departments' student placement coordinators office. Staff electronic signatures on this document are also acceptable and records are available through the Department of Education and Training.
  - d. Volunteers do not access resident medical records nor chart in the medical record.
  - ~~d.~~e. Similar requirements for business associates (BA's) are described in BA contracts.

## 5. Handling of PHI

- a. Copies of PHI are to be discarded directly into the confidential bins when no longer needed.
- b. Copies of PHI (electronic or hard copy) are not to be left in open view.
- c. PHI discussed at resident care conferences and other team meetings is for the sole purpose of providing care and is to be kept confidential.
- d. PHI shared as part of internal quality improvement efforts, such as
  - i. Performance Improvement Committees, is used for informational purposes to continuously improve practice and outcomes.
- e. Reports with PHI are shared with staff on a "need to know" basis, secured from privacy breaches and discarded in the confidential bin for shredding, when no longer needed.

## 6. Reporting Privacy Breaches

- a. ~~All staff, students, and volunteers receive initial HIPAA training utilizing the DPH curriculum. In addition, annual re-training is provided to all staff through the Department of Education and Training. Managers are responsible for assuring compliance.~~
- b. An Unusual Occurrence report shall be completed for a suspected privacy breach.
- c. Suspected privacy breaches are reported to the [LHHaguna Honda](#) Privacy Officer for follow up.

### **ATTACHMENT:**

Appendix A: Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms

### **REFERENCE:**

LHHPP 21-01 Medical Records Information: Confidentiality And Release  
LHHPP 21-02 Transmission of Confidential Medical Information Via Facsimile  
LHHPP 21-05 Medical Record Documentation  
LHHPP 21-06 Transporting the Resident's Filed Medical Records  
LHHPP 24-08 Off Campus Appointments Or Activities  
LHHPP 29-02 Resident as Photography or Interview Subject  
LHHPP 29-07 Human Subject Research

LHHPP 60-01 Performance Improvement Program

[User Agreement for Confidentiality, Data Security and Electronic Signature Confidentiality Agreement for Staff, Volunteers and Affiliating Students](#) (Available at [www.sfdph.org/DPH/privacy](http://www.sfdph.org/DPH/privacy) and the LHH intranet/ LHH forms)

(Source: <http://www.sfdph.org/dph/files/HIPAAdocs/PrivacyPolicies/Form-ConfidSecElecSigAgrmnt06252010.pdf>)

[California Health Information Privacy Manual, California Hospital Association \(CHA\), November 2014, 7<sup>th</sup> edition.](#)

Revised: 13/01/29, 13/09/24, 15/09/08 (Year/Month/Day)

Original adoption: 11/09/27

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## **Appendix A - Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms**

### **DPH Privacy Policies**

(Available at: <http://dphnet.dph.sf.ca.us/node/316> [www.sfdph.org/DPH/privacy](http://www.sfdph.org/DPH/privacy))

1. Privacy Policy
2. Authorization for Use and Disclosure of PHI
3. Privacy and the Conduct of Research
4. Patient / Client / Resident Rights Regarding PHI
5. Administrative Requirements
6. User confidentiality and Security Agreement
7. Use of PHI in Disciplinary Investigations and Proceedings
8. Secured Delivery of PHI Interoffice, Mail, Fax
9. Reporting of Unlawful or Unauthorized Access of PHI
10. Reporting Individuals with Lapse of Consciousness to DMV
11. Electronic Data Security Policies User Brief

### **DPH Data Security Policies**

(Available at: <http://dphnet.dph.sf.ca.us/node/316> [www.sfdph.org/DPH/privacy](http://www.sfdph.org/DPH/privacy))

1. DPH Electronic Data Security Policies – User Brief
2. Access Control Policy
3. Confidentiality, Security, and Electronic Signature Agreement
4. Disaster, Contingency and Business Continuity Planning
5. Data Backup
6. Policy for Classification of Data
7. Data Network Security
8. Security Documentation and Accountability
9. Malicious Software Prevention and Surveillance
10. Policy for Secure Disposal or Reuse of Media Containing Critical Data
11. Network Operating System Architecture and Administration
12. SFDPH Password Policy
13. Portable Computer and PDA Security
14. Remote Network Access Policy
15. Risk Analysis and Risk Management
16. Policy for Secure Storage, Disposal or Reuse of Media Containing Critical Data
17. Secure Transmission of Protected Health Information
18. Security Activity Logging, Tracking and Reporting
19. Security Policy Violation Discipline and Sanctions
20. Security in the System and Software Development Process
21. Security Awareness, Orientation and Training
22. Wireless Network and Information Transmission Security
23. Workstation, Data Display and Printout Security Policy

## **DPH Privacy Forms**

(Available at: <https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/default.asp>  
<http://dphnet.dph.sf.ca.us/Privacy/default.htm#Forms>)

### DPH Privacy Policy Matrix

1. DPH Authorization to Disclose PHI
2. CBHS Authorization for Use or Disclosure of PHI
3. DPH Research Proposal Approval Form
4. Health Information Data Use Agreement and Form
5. Summary DPH Notice of HIPAA Privacy Practices
6. Detail DPH Notice of HIPAA Privacy Practices
7. User Confidentiality and Security Agreement Form
8. PHI Cover Sheet Required for Fax, Interoffice, Mail
9. Summary of Unauthorized Access of PHI
10. HIPAA Business Associate Addendum

## **MEDICAL RECORD DOCUMENTATION**

### **POLICY:**

It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) that:

1. Medical record systems 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 Laguna Honda 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 Laguna Honda is seeking reimbursement from government and non-government payers 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 and Rehabilitation Center. 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 Laguna Honda.

### **PROCEDURE:**

#### **1. 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:
  - i. A complete history and physical examination;
  - ii. Initial diagnostic impression;
  - iii. Diagnostic reports (such as consultation, clinical laboratory, electrocardiogram, x-ray and others);
  - iv. Records of medical and/or surgical treatment;
  - v. Records of pathologic findings;
  - vi. Progress notes; and
  - vii. 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. 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:
  - i. Licensed practitioners,
  - ii. Other credentialed health professionals,
  - iii. Physicians in post graduate residency programs, nursing staff and allied health professions students.

## 2. The Hybrid Medical Record

- a. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) maintains paper-based and computer based medical records. This hybrid computer based medical record 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 use both paper-based and computer-based medical records (e.g. reports/notes and measurements entered into the [Lifetime Clinical Record \[LGR\] system or electronic Clinical Works \[eCW\] systemhealth record](#)) to review 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.



- b. The hybrid medical record system utilizes an electronic signature application for transcribed medical reports dictated or typed by the clinical staff.
- c. The hybrid medical record is managed through a formal process by the Laguna Honda Information System (IS) Steering Committee (refer to Appendix A – Guidelines for transitioning from paper-based to the electronic medical record system).

### **3. 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.
  - i. The resident/patient's medical record clearly, accurately and legibly conveys that:
    - the services have been provided;
    - the services were appropriate for the resident/patient's condition, and
    - the services meet reasonable standards for medical care.
  - b. 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.
  - c. 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.
  - d. Assessment, clinical impression or diagnosis is recorded.
  - e. A plan of care and/or a description of the care rendered during the encounter are documented.
  - f. The resident/patient's progress, response to changes in treatment, and any revision to the diagnosis is documented.
  - g. Health risk factors specific to the resident/patient are documented.
  - h. The date and time, and the legible identifier (Name, signature and title)
  - i. Each entry must be able to "stand alone" and support the test, and/or service being reported.

### **4. 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:
  - i. The diagnosis(es) or finding(s) that best justifies the need for the service(s). This may be the same reason for the hospital admission or clinic visit.
  - ii. The ordering/referring physician's signature, title, and CHN ID number.

## 5. Responsibilities of the Teaching-Treating 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 Laguna Honda.

## 6. Authentication

- a. All medical record entries must be timed and dated. 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.

## 7. Correcting and Amending Entries

- a. The Paper Record
  - i. Correcting an erroneous entry  
Any corrections should be made by drawing one line through the erroneous entry, writing "error" in the margin and initialing it. Do not

erase or otherwise obliterate the erroneous entry; it should remain legible.

ii. 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:

- Label the entry as a late entry or an addendum.
- Date and time the entry when it was written (do not back date the entry).
- Sign the entry.
- 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.
- The late entry or addendum should not obliterate any earlier entry.

b. The Electronic Record

Refer to LHHPP 21-07 Handling Misfiled [Electronic Health Records](#)~~LCR~~  
~~Reports/Notes~~

**ATTACHMENT:**

Appendix A: Guidelines for transitioning from paper-based to the electronic medical record system

**REFERENCE:**

LHHPP 21-07 Handling Misfiled [Electronic Health Records](#)~~LCR~~ ~~Reports/Notes~~  
[NPP G1.0 Vital Signs](#)

NPP G4.0 Measuring the Resident's Height and Weight

[San Francisco Department of Public Health Use of Scribes for Electronic Charting in San Francisco Health Network Electronic Health Records Policy and Procedure](#)

Revised: 13/01/29, 15/03/24, 15/09/08 (Year/Month/Day)

Original adoption: 09/04/14

**Appendix A:****Guidelines for transitioning from paper-based to the electronic medical record system**

The hybrid medical record is managed through a formal process by the Laguna Honda Information System (IS) Steering Committee using the following guidelines:

1. The transition and expansion of the electronic medical record shall be systematically planned and managed administratively, financially, organizationally and culturally.
2. There shall be a formal process for approving electronic medical record software and hardware to ensure that the system can adequately support the facility's operational needs.
3. The same Federal and State confidentiality, privacy and security regulations that govern the paper based medical record are also applicable to the electronic medical record.
4. The Laguna Honda Information System (IS) Steering Committee, which reports to the Hospital Executive Committee, will establish an interdisciplinary sub-committee when needed to guide the organization to effectively transition from a paper based medical record system to an electronic medical record system.
5. The designated sub-committee will develop and publish procedures relevant to the medical record component being transitioned from the paper based format to the electronic format and notify clinical and administrative users of the change in workflow.

6. The following ~~A legend of document and report types, that describes where and how to access the electronic-hybrid medical record system currently in use: -will be published and updated by the Health Information System Department and posted on the Intranet.~~

The Skilled Nursing Facility (SNF) neighborhoods have adopted eClinical Works for physician documentation in the clinics and SNF bedside visits. Psychiatry and substance abuse treatment notes are via AVATAR. This document provides an outline of where information is found for LHH patients.

<u>Type of Documentation</u>	<u>Location</u>
<u>Physician bedside visit progress note SNF</u>	<u>eCW, locked notes also appear in LCR</u>
<u>Annual, Admission H&amp;P, Discharge Physician Notes</u>	<u>eCW and/or LCR</u>
<u>Medication orders (oral, ophthalmic, ENT, Injection)</u>	<u>eCW</u>

<a href="#">Medication orders topical ointments, creams, shampoos, wound care products</a>	<a href="#">Paper chart</a>
<a href="#">Complete medication list with original order dates</a>	<a href="#">Paper Medication Administration Record</a>
<a href="#">Nursing, Nutrition, Social Services, Activity Therapy Charting</a>	<a href="#">Paper chart</a>
<a href="#">Care Plans</a>	<a href="#">Paper chart</a>
<a href="#">Psychiatry</a>	<a href="#">Avatar, some appear in LCR and behavioral health folder within eCW</a>
<a href="#">Substance Abuse</a>	<a href="#">Avatar</a>

6-7. The IS Steering Committee shall evaluate the effectiveness and adequacy of each electronic medical record component implemented, improving processes as necessary, with the goal of transitioning the facility to a paperless environment.

## THREATS OF VIOLENCE TO RESIDENTS BY AN EXTERNAL PARTY

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall provide an appropriate level of safety and security for residents who become the subject to threats of violence.

### PURPOSE:

To establish a plan of action to address threats of violence against residents and to assure resident safety and security.

### PROCEDURE:

1. Upon receipt of an alleged threat of violence against a resident by an external entity:
  - a. The employee receiving the call shall immediately notify their immediate supervisor and the San Francisco Sheriff's Department (SFSD) duty officer (~~via Hospital Operator x 4-2999~~ at extension 4-2319) and report the nature of the threat with as much detail as possible.
  - b. The ~~Laguna Honda Operator~~ Supervisor shall notify the ~~SFSD and the~~ Chief Operating Officer (COO) or designee.
  - c. The SFSD duty officer shall respond immediately.
  - d. The supervisor shall document the facts of the event.
  - e. The COO shall notify the Chief Nursing Officer (CNO) and the Medical Director.
2. The Medical Director, CNO, and COO, or designees, shall immediately confer to ascertain the relative degree of merit of the threat and to take any or all of these appropriate actions:
  - a. Notify the nursing unit of the situation. Initiate "John Doe" status for the resident, so that no information is given out by any department, employee, or volunteer regarding the resident's location in the facility.
  - b. If the resident's current unit is thought to be known to the alleged threatening party, relocate the resident for additional safety, as well as initiate "John Doe" status.
  - c. The COO shall confer with SFSD and request that officers make additional patrol rounds through the subject area; provide an immediate response to any call to

that area; or establish a fixed-post, if necessary, to enhance protection of the resident's safety. The COO will provide available information about the threatening party to the SFSD.

- d. If deemed necessary, the COO may instruct staff to notify the San Francisco Police Department and to request police assistance.
  - e. If adequate cause exists, the COO may contact the City Attorney to request a Temporary Restraining Order to keep the threatening party off Laguna Honda property.
  - f. The COO may instruct the Hospital's Social Services Department to investigate and provide details regarding the source of the threat (spouse, family, acquaintance, etc.).
3. "John Doe" status confers immediate status changes:
- a. Admitting and Eligibility (A&E) removes the resident's name from daily A&E census printout.
  - b. No information may be given out regarding the resident by the department, employee, or volunteer; no acknowledgement of the resident's presence on-site or residency at Laguna Honda is permitted.
  - c. No deliveries of flowers, mail, packages, etc. from outside parties without resident's permission.
4. The facility will take other case-by-case measures as necessary to assure a reasonable level of resident safety and security.

~~—Participating managers will document and initial all special procedural measures taken on the attached form and will forward it to the Quality Management Department, where these forms will be kept in a case file.~~  
~~There is no form attached to this P & P — Suggest to delete # 5~~

**REFERENCES:**

None

Revised: 92/05/02, 96/07/15, 10/06/08, [15/09/08](#) (Year/Month/Day)

Original adoption: 92/03/02

## OFF CAMPUS APPOINTMENTS OR ACTIVITIES

### POLICY:

1. Escorts shall be provided with the necessary training and or information for resident safety.
2. Staff, volunteers, peer mentors, resident family members/surrogate decision-makers and their approved friends may escort a resident to an off campus appointment or activity, if deemed appropriate through an assessment by the Resident Care Team (RCT).  
~~Escorts shall be provided with the necessary training and or information for resident safety.~~

### PURPOSE:

To ~~enhance resident experience and~~ provide resident safety and supervision ~~while during~~ off campus appointments or activities.

### PROCEDURE:

#### 1. Assessment and Documentation

- a. The Resident Care Team (RCT); comprising at a minimum, a physician and the licensed nurse; shall determine
  - i. if a resident needs to be accompanied by an escort, ~~and~~ and
  - ii. the ~~person~~ escort must be deemed appropriate to accompany ~~suitable to serve as a escort for~~ the resident.
- b. A physician's order shall be written for ~~the resident off campus appointment or activities, including:~~
  - Transportation to be used, and
  - If escort will be necessary.~~and specify the escort who will accompany the resident and the mode of transportation to be used.~~
- c. A physician shall be responsible for completing referrals for off-campus medical appointments.

#### 2. Transportation



- a. The Physician shall complete the Transportation Prescription Form for any off-site appointments needing transportation arranged by Admission and Eligibility (A&E).
- b. The Unit Clerk or designee shall:
  - i. fax the Transportation Prescription Form to A&E to arrange transportation services.
  - ii. write the appointment on the Treatment Authorization Record (TAR) and the Neighborhood's calendar.
  - iii. complete the Transportation and Appointment Ticket and attach it to the specially designated envelope for off-site appointments.
- c. Nursing and non-nursing staff may escort the resident using a hospital vehicle or contracted transportation service.
- d. If the contracted transportation service is unable to fulfill the transportation arrangement, the Nurse Manager or designee may arrange alternative transportation, including use of hospital vehicle or taxi service, to transport the resident to the appointment and or back from the appointment.

e. Use of Taxi Service:

- i. Taxi service is used when the contracted transportation is unable to pick up or drop off resident to appointments.; ~~When~~ when the resident ends up to be admitted to acute hospital and escort ~~needs-is-needng~~ to return back to hospital use public transportation unless considered as over time.
- ii. ~~Taxi Vouchers are available in the Nursing Office.~~ The Nursing Office Supervisor is the designated safe keeper of the taxi voucher, and shall provide oversight of the process, including the reconciliation of the used of vouchers to ensure accurate accounting of the funds used.
- iii. Taxi Vouchers are available in the Nursing Office. (A receipt is submitted to Nursing Office whenever a Taxi Voucher is used, including completion of the log to reflect date, amount used and staff who voucher was issued to).
- iv. Vouchers are in triplicate form: the original copy shall be given to the taxi driver; the second copy (yellow) for Finance Department; and the third copy (pink) shall be filed in the Nursing Office.

- v. Nursing Office submits the receipt and log to Accounting on a monthly basis for invoice payments to replenish the Taxi Vouchers when the remaining amount number of voucher is less than \$50.00.
- vi. In the absence of an approved taxi voucher, a staff member may provide personal funds as necessary in the event of a transportation need for patients/residents. The staff member shall be entitled to be reimbursed of all funds used by completing properly the "Employee Expense Authorization and Reimbursement Form", which is being kept in the Nursing Office.

### 3. Request for Nursing Staff Escort

- a. When a ~~staff nurse~~ nursing staff escort is needed to accompany the resident to an off-site appointment or activity, the ~~Nursing~~ nursing staff shall carry out the following steps according to the timeline established below:
  - i. The Day the Transportation Prescription is written by the Physician:
    - Fax the completed Transportation Prescription form to Nursing Office.
    - Write a reminder ~~on the~~ on the calendar ~~the day before the scheduled appointment~~ to "call nursing office the day before the scheduled appointment to confirm an escort."
  - ii. The Weekend prior to the appointment:
    - In order to assign an escort, Nursing Office Staffer ~~will~~ shall call the neighborhood the weekend prior to the appointment ~~to confirm~~. Once confirmed, the ~~Nursing Office Staffer~~ shall assign an escort for the scheduled date ~~requested~~.
  - iii. The Day before the appointment:
    - The Neighborhood ~~shall~~ will call the Nursing Office ~~the day before the appointment~~ to confirm the escort requested.
  - iv. The Day of the appointment:
    - The Charge Nurse or designee will:
      - give hand off report to the escort, and
      - provides the escort with the completed Transportation and Appointment Ticket enclosed in a specifically designated envelope for off-site appointment.

- The Escort shall:
  - obtain hand off report from the Charge Nurse or designee.
  - upon return to Laguna Honda:
    - ~~handhand~~ the Transportation and Appointment Ticket back and give a verbal report to the charge nurse.
    - ~~and give verbal report as to how the appointment went~~ report back to the Nursing Office once resident has been returned to the neighborhood. ~~and report has been given~~
- ~~The Charge Nurse or designee shall:~~
  - ~~give hand off report to the escort~~
  - ~~hand the completed Transportation and Appointment Ticket attached to the specifically designated envelope for off-site appointment to the escort.~~

#### 4. Medical Record Information needed for off campus appointment

- a. Information shared for off campus appointments shall be the minimum necessary for treatment or billing purposes during the appointment.
- b. For SFGH clinic visits, only the clinic addressograph card (currently a gold card) and the transport ticket shall accompany the resident.
- c. Whenever possible, the staff at the appointment destination shall access the needed information electronically (i.e. on the LCR or eCW for SFGH clinics.)
- d. When needed information is not ~~on-in~~ the LCR or eCW or the clinic does not have access to the SFDPH ~~LCR~~ electronic health records, the medical record information may be processed through the medical records department or faxed securely to the clinic according to the facility's facsimile transmission process (as described in LHHPP File 21-02 Transmission of Confidential Medical Information via Facsimile).

#### 5. Non-staff Escort

- a. Family or Surrogate Decision-Makers and Approved Friends as Escorts
  - i. The RCT designee shall contact and make arrangements for the resident's family or surrogate decision-makers or approved friend to accompany the resident to an off campus appointment or activity.
  - ii. Resident families or surrogate decision-makers or their approved friend shall be trained by the Charge Nurse or designee.

iii. Resident families or surrogate decision-makers and their approved friends may transport the resident using their personal vehicles or contracted transportation service.

b. Volunteer Escorts [\(when available\)](#)

i. When the RCT determines that a volunteer escort is appropriate to accompany the resident to an off campus activity, the RCT designee shall submit a request to the Volunteer Services Department for a volunteer to escort the resident.

ii. The Volunteer Services Department shall recruit for a volunteer to escort the resident and notify the Charge Nurse or designee.

iii. The Charge Nurse or designee shall introduce the volunteer to the resident and provide pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Volunteers shall escort the resident using contracted transportation service or public transportation.

c. Peer Mentor Escorts [\(when available\)](#)

i. When the RCT determines that a peer mentor is appropriate to accompany the resident to an off campus activity, Social Services shall submit a referral request to the Peer Mentor coordinator.

ii. The Peer Mentor Program Coordinator shall recruit a peer mentor to match with the resident and notify the Social Worker.

iii. The social worker shall introduce the peer mentor to the resident and the peer mentor shall check in with the Charge Nurse or designee prior to outings for any pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Peer mentors shall escort the resident using contracted transportation service or public transportation.

**ATTACHMENT:**

Attachment A: Transportation and Appointment Ticket

**REFERENCE:**

LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile  
LHHPP 21-06 Transporting The Resident's Filed Medical Records On Campus  
LHHPP 24-20 Close Observation  
MR908 Transportation Prescription  
[\[Add reference re training escorts\]](#)

Revised: 96/07/15, 99/01/12, 12/07/31, 13/05/28, 13/09/24, [15/09/08](#) (Year/Month/Day)

## **AMBULANCE CALLS-UTILIZATION AND ACCESS**

### **POLICY:**

~~It is the policy of~~ Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) ~~to~~ will utilize routine and emergency transportation in accordance with agreed-upon Emergency Medical Services (EMS) and Laguna Honda standards.

#### LHH Contracted Ambulance Providers

<u>Name of Ambulance provider/Provider/ Contact #</u>	Type of Service
<b>Primary:</b> American Medical Response 1-800-540-3066 or 1-800-913-9197	Advanced Life Support (ALS) Basic Life Support (BLS)
<b>Primary:</b> Pro Transport <u>Telephone #: 1-800-650-4003</u>	<ul style="list-style-type: none"> <li>• <u>Basic Life Support (BLS) Non-Emergent</u></li> <li>• <u>BLS Emergent</u></li> <li>• <u>Advanced Life Support (ALS) Non-Emergent</u></li> <li>• <u>ALS Emergent</u></li> <li>• <u>Specialty Care Transport (SCT)</u></li> <li>• <u>Urgent and Non-Urgent Routine and Bariatric Transport</u></li> <li>• <u>Wheel Chair Van</u></li> </ul>
<b>Secondary:</b> <del>St. Joseph's Ambulance Service</del> <del>415-921-0707</del> <u>King American Ambulance</u> <u>Need telephone #</u> <u>Telephone #: 1-415-931-1400</u> <u>Fax #: 1-415-621-2100</u>	<ul style="list-style-type: none"> <li>• <u>BLS-ALS Non-urgent</u></li> <li>• <u>ALS Emergent</u></li> <li>• <u>BLS Non Emergent</u></li> </ul>
<b>Tertiary:</b> American Medical Response <u>Telephone #: 1-800-540-3066 or</u> <del>1-800-913-9197</del> <u>Pro Transport</u> <del>1-800-650-4003</del>	<ul style="list-style-type: none"> <li>• <u>Advanced Life Support (ALS)</u></li> <li>• <u>Basic Life Support (BLS)</u><u>BLS Non-Emergent</u></li> <li>• <u>BLS Emergent</u></li> <li>• <u>Specialty Care Transport (SCT)</u></li> <li>• <u>Urgent and Non-Urgent Routine and Bariatric Transport</u></li> <li>• <u>Wheel Chair Van</u></li> </ul>

### **PURPOSE:**

To assure safe and timely transfer of residents to acute care or medical appointments in the community outside the facility\_ utilizing at the appropriate service level of care.

**DEFINITION:**

1. Basic Life Support (BLS): Emergency first aid and cardiopulmonary resuscitation procedures which, ~~as at~~ a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the patient-resident can may be safely transported or until advanced life support is available.
- ~~2. Basic Life Support BLS Ambulance: An ambulance that is staffed with a minimum of two EMT-I personnel and has the required basic life support (BLS) equipment and supplies.~~
- ~~3.2. Advanced Cardiac Life Support (ACLS): Means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specific drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized-certified personnel under the direct supervision of a base hospital. ~~All ALS units responding to emergency calls are staffed with two EMT-Paramedics certified and accredited to practice in the City and County of San Francisco.~~~~
- ~~4.3. Specialty Care Transportation (SCT): Ground medical transportation services that exceed the normal scope of paramedic practice-services and require a higher trained level of personnel and additional equipment.~~

Note: Special transport situations include but are not limited to any of the following conditions:

- ~~a. Obesity (>250 lbs.)~~
- ~~b. Cervical immobilization~~
- ~~a.c. BiPAP or CPAP support required~~
- ~~b. active infectious disease~~
- ~~c. massive bleeding~~
- ~~d. intubation~~
- ~~e. need for special approach or restraints~~

**PROCEDURE:**

1. Transfers of residents outside of LHH

~~a. Transfers outside of LHH include non-urgent transfers (i.e., scheduled routine transport) and emergent medical transfers. Laguna Honda~~

~~A.B. fall into two broad categories: (1) non-urgent transfers or scheduled routine transport and (2) emergent acute medical transfers. The physician on-scene must triage acute medical transfers using 3 acuity categories:~~

~~Code 1 = Medically stable but requires ambulance response within 1 hour or less.~~

~~Code 2 = Medically unstable; requires ambulance response within 20 minutes or less.~~

~~Code 3 = Immediately life threatening conditions; requires ambulance response within 8-10 minutes or less.~~

~~Note: If the urgency of transport is unclear, the physician, nursing operations nurse manager/supervisor, or charge nurse should call 911 for assistance in triage.~~

### **1. Non-urgent, routine transfers or scheduled routine transport:**

~~b. Non-urgent, routine transfers are generally pre-arranged, however circumstances may arise requiring placement of order request for services should not be placed by telephone. A written transportation order is necessary.~~

~~a.c. The transportation order must be fully completed and signed by the physician, and includes the resident's diagnosis relating to the purpose of the transfer/medical appointment, as required by the payer.~~

~~b.~~

~~c. Diagnosis relating to purpose of the transfer/visit is, as required by Medi-Cal, mandatory (for Medi-Cal).~~

~~In the case of ambulance orders, the physician must state a justification for ambulance use. Medi-Cal does not cover all ambulance transports and accepts or denies accordingly. Medicare does not cover ambulance unless patient is discharged from SNF. Laguna Honda (under Prospective Payment System-PPS) assumes cost of ambulance transport for Medicare residents.~~

~~i. Procedure for non-urgent transfers or scheduled routine transport:~~

~~d. During off-hours, weekends/holidays, transportation is arranged directly with the ambulance company by the licensed nurse.~~

~~e. During regular business hours, 8:00am – 4:00pm the transportation prescription is faxed to (415) 682-5689-5689 or hand-delivered or via inter-office mail to A&E at Pavilion Ground (PG123).~~

~~f. A&E will fax the transportation prescription to the ambulance provider.~~



- [g.](#) A&E will provide and confirm [the](#) transportation arrangement to the licensed nurse or unit clerk.
- [h.](#) Inquiries and concerns ~~should are to~~ be addressed with A&E (located at PG123) at extension 4-5680 or 4-5681.
- [i.](#) Do not call A&E for STAT or 911 transfers, as ~~these are this is~~ the responsibility of the health care team members, charge nurse or nursing operations nurse manager/supervisor.

## 2. Bariatric Transports [\(Non-Urgent\)](#)

- a. Pro Transport can accommodate bariatric transportation with a bariatric gurney.
  - i. Arrangement must be made [with](#) as much ~~in~~-advance [notice](#) as possible to ensure that the gurney is available.
  - ii. Pro Transport ~~waits with~~ [will provide](#) the gurney ~~when for~~ the resident ~~attends going to~~ the appointment.
  - iii. ~~If the appointment takes more than an hour, a fee of \$15.00 per 15 minutes will be charged.~~

## 3. Urgent Bariatric Transports

- a. Pro Transport also provides urgent bariatric transportation services.
  - i. The bariatric gurney is not stored on site, so allow [time for the](#) transportation service ~~time~~ to pick up the ~~ir~~ gurney before ~~arriving coming at to~~ Laguna Honda.

## 4. Emergent acute medical transfers

- a. **Code 1 transfers:** For residents who are medically stable but require basic life support (BLS) ambulance, ~~staff can anticipate a response time of approximately round 1 hour or less dependent~~ [subject to the on-availability of resources response within 1 hour or less:](#)
  - i. Call [the](#) primary contracted [ed](#) ambulance company, ~~American Medical Response (AMR), at 800-913-9197.~~
  - ii. [The](#) Laguna Honda physician, nursing operations nurse manager/supervisor or charge nurse ~~must~~ [will be asked to](#) :
    - ~~Ddescribe the resident and the immediacy of response needs;~~

- Provide information regarding the resident's status and needs related to transport.
  - state whether basic EMT or advanced life support Paramedic Ambulance is needed; and
  - provide other information as requested by the ambulance dispatcher. Based on standardized criteria, the dispatcher will determine whether an appropriate ambulance team is available and state an estimated time of arrival.
- iii. If the primary contracted ambulance service is not able to cannot arrive within an appropriate time an hour, call the secondary or the third tertiary ambulance company and request for transportation services to transfer of a patientthe resident. If the alternate ambulance company cannot arrive in time; and it is urgent that the resident be transported, call 911.
- Note: If you have called a private ambulance company and subsequently need to call 911 because of the patient's-resident's condition is deteriorating condition, please-be sure to call the private ambulance back and tell them not to come.
- b. **Code 2 transfers:** For medically unstable residents who require advanced cardiac life support or ALS ambulance response within 20 minutes or less:
- i. Call the primary ambulance company, ~~American Medical Response (AMR), at 800-913-9197~~ or 911 and request a paramedic unit.
  - ii. The Laguna Honda physician, nursing operations nurse manager/supervisor or charge nurse must:
    - state this call is for a Code 2 transfer for a deteriorating or acute patient; but the condition is not immediately life-threatening (i.e., not Code 3); and
    - provide other information requested by the ambulance dispatcher. The dispatcher will use standardized criteria to triage the call and dispatch an appropriate unit. Lights and sirens will not be used.
- c. **Code 3 transfers:** Immediately life-threatening situations (lights/sirens; ambulance response time 8-10 minutes or less with ALS paramedic transfer):
- i. Call 9-1-1 directly from the wardneighborhood.
  - ii. Laguna Honda physician, nursing operations nurse manager/supervisor, or charge nurse:

- Must state that this is a Code 3 transfer for a life-threatening medical emergency and
  - describe the resident's condition and the immediacy of response needs.
- iii. After 911 is called, alert the Laguna Honda ~~operator~~ Sheriff's Department regarding the exact location ~~to which~~ where arriving emergency personnel ~~should proceed~~ is needed.

~~Note: The S. F. Fire Department responds to >90% of all 911 calls and Fire personnel thereby are available to drive the ambulance while the paramedics focus on patient care.~~

- ~~• The nearest paramedic unit will respond with lights and sirens for 911 and Code 3 calls. Therefore, when deciding whether a resident requires Code 3 transport, be aware that rapid responses with lights and sirens expose the paramedics and the general public to some risk due to the potential for motor vehicle accidents.~~
- ~~• Notify the ambulance dispatcher of special transport situations (refer to Definition 4. Specialty Care Transport for types of special transport situations).~~

## 5. Communication with hospital to which patient is referred to

- a. When 911 is called regarding immediate life-threatening situations (Code 3):
- i. the paramedics will determine ~~the which~~ hospital ~~to which~~ the resident ~~is will~~ be transported to; ~~taken~~ and in most ~~cases~~ instances the resident will be transported ed to UCSF Moffett/Long Hospital, ~~which~~ because it is geographically closest to Laguna Honda; ~~or~~
  - ~~ii. the Laguna Honda physician can designate a different hospital by communicating with the base physician at the SFGH ER (206-8111); and~~
  - ~~iii.~~ ii. ~~in either case~~ the Laguna Honda physician ~~should~~ shall call the designated receiving ER to provide ~~appropriate~~ necessary medical information.
  - ~~iv.~~ iii. For 911 calls, a staff member ~~will go~~ is sent to wait at the Pavilion entrance to escort EMS to the neighborhood.
- b. When residents are transferred for acute medical problems (other than Code 3):

- i. The Laguna Honda physician ~~must~~ shall communicate with the emergency room attending physician at the receiving hospital before sending the ~~patient~~ resident, or as the ~~patient~~ resident is being transported.
- ii. In general, ~~patients-residents should~~ shall be sent to SFGH (after calling the E. R.) unless SFGH is on diversion or the ~~patient~~ resident has a health plan which determines where acute care must be ~~given~~ provided (e.g., Kaiser). Also, if the ~~patient~~ resident or family requests transfer to another hospital, that request ~~should~~ shall be honored, if possible.
- ~~iii. If SFGH is on diversion, the Laguna Honda physician should call the emergency room physician at UCSF or other private hospitals.~~
- ~~iv.~~ iii. A copy of the resident's Advance Directives ~~should~~ shall be included in the resident transfer packet.

**ATTACHMENT:**

None

**REFERENCE:**[LHHPP File: Code Blue](#)[LHHPP File: Chest Pain Protocol](#)[NPP Discharge to Acute](#)[Medical Staff P&P](#)~~None~~Revised: 00/03/09, 11/09/27, 12/03/27, 15/09/08 (Year/Month/Day)

Original adoption: 98/11/16

## RESIDENT AS PHOTOGRAPHY OR INTERVIEW SUBJECT

### POLICY:

1. No photograph, interview (recorded or unrecorded), video, or other image, nor any taped or other recording of any resident shall be permitted by hospital staff or others to be taken or made, unless the resident ~~/-~~ decision maker has provided signed written consent and release according to this approved process prior to the event.
2. Laguna Honda staff shall comply with Department of Public Health policies and procedures on Authorization for Use and Disclosure of Protected Health Information (PHI) and other Privacy policies.

### PURPOSE:

To protect the right of residents to privacy and to assure that public access and scrutiny does not ~~subjects~~ ~~no~~ ~~residents~~ to an invasion of privacy.

### CHARACTERISTIC:

The right to privacy is an established right of all residents. - The nature of "privacy" has been established in the courts to include freedom from unwilling participation in visual and audio recording made on the hospital premises as well as interviews unrequested or unwanted by the resident ~~/-~~ decision maker. - Acknowledgment of the resident's participation in control of the environment is essential to everyone's well-being.

### PROCEDURE:

1. Laguna Honda routinely obtains authorization and consent to photograph as part of the admissions process for resident identification purposes and emergency use **only**, as outlined in the admissions agreement.
2. Obtain a signed written consent and release prior to photographing, interviewing, and other recording of the resident (use form MR802 ~~available through Materials Management, Pathways Horizon Supply Source~~). The original signed form must be filed in the resident's chart and the copy is offered to the decision maker.
3. Staff must not allow visual/audio recordings until proper written authorization is requested and granted in writing by the resident ~~/-~~ or surrogate ~~decision~~ - maker. Media visits or requests that originate from a resident request require the same written approval by the resident.
4. ~~Identifiable photos, videos, or information about current, past, or deceased residents who have been diagnosed with or receive services for mental health or substance abuse may not be released or published, even if the resident authorizes or requests~~

~~that you do so. LHH staff and others are not to include identifiable residents in photos or personal stories that disclose their current or past mental health issues or substance use, HIV status, or engagement in behavioral health services.~~

~~5. Only residents who are capable of making their own decisions and surrogate decision makers or conservators may authorize the release of resident information or pictures.~~

~~6. Contact the communications office for consent forms for interview, photo, or recording or access the document on the Laguna Honda intranet under "Forms".~~

~~7.4. The original signed form must be filed in the residents chart and the yellow a copy is offered to the resident/ decision maker. ~~must be filed in the administration office.~~~~

~~8.5. Failure of employees to enforce this policy and procedure may result in disciplinary action.~~

~~9.6. Media inquiries: refer to LHHPP 01-08 Media Relations Policy~~

**REFERENCES:**

LHHPP 01-08 Media Relations Policy

DPH Policy Authorization for Use and Disclosure of PHI (Source: <http://10.80.12.69/dph/files/HIPAAdocs/PrivacyPolicies/HIPAAPrivacy-AuthorizationPol02242010.pdf>)

Revised: 92/05/20, 10/04/27, 10/08/24, 13/01/29, 15/07/30, 15/09/08 (Year/Month/Day)

Original adoption: 92/05/20

## UNUSUAL OCCURRENCES

### POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) that Hospital personnel ~~primarily use~~ utilize a the electronic Hospital-wide Unusual Occurrence reporting system to ~~report, and document~~ report document follow-up investigations, communicate with relevant personnel and document corrective actions related to unusual occurrences ~~events~~.
2. An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.
3. Unusual Occurrence reports (UOs) shall be completed and timely submitted by the charge nurse, department/unit manager or designee, or any employee who witnesses or becomes aware of an unusual occurrence. The initial report should be completed by the first staff member responding to an event and those who are most knowledgeable about the occurrence.
4. UOs are confidential under Evidence Code 1156/1157. No ~~photo~~copies are to be made except by Quality Management staff. ~~Any photocopies are, by definition, unauthorized.~~
5. The Quality Management (QM) Department will maintain UOs as part of Performance Improvement Committee records.
6. Access to the Performance Improvement Committee records and reports will be strictly limited to QM staff, Departmental and Hospital Performance Improvement Committees, Medical Executive Committee, and Joint Conference Committee.

### PURPOSE:

The purpose of the Unusual Occurrence system is to identify these events or conditions and institute corrective action that will address immediate needs and prevent similar future incidences. The system will also allow evaluation of potential legal exposure and, if necessary, will initiate preparations for an appropriate legal defense by the Deputy City Attorney's Office.

### PROCEDURE:

#### 1. General Provisions

- a. Filing a UO in no way replaces the ongoing responsibility of individuals to take action as necessary, investigate the occurrence, follow up appropriately,

including referral to Human Resources, and report problems as they occur through the normal supervisory channels.

- b. Malicious reports or reports with punitive intent are not appropriate. Interdepartmental conflict should be discussed by the departments involved and reported on a UO only when not resolved in a timely manner.
- c. The ~~Hospital-wide~~ Performance Improvement and Patient Safety –Committee (HWPIGPS), a Committee of the Medical Staff, is responsible for reviewing and evaluating Unusual Occurrence Reports as part of the Hospital Performance Improvement Program.

## **2. Reporting, and Investigation and Follow-up Procedure**

~~d.~~a. Before the end of the work shift, the ~~reporting employee~~ Charge Nurse, reporting employee, or designee:

- i. Completes the on-line UO which is directly transmitted to the Quality Management Department.
- ii. Necessary information for completing the UO:
  - Include the name of patient/resident (if applicable), unit, date of occurrence, time of occurrence, description of incident and person(s) notified.
  - Include the name(s) of staff, visitors, volunteers, students and other residents who were involved in the incident or witnesses to the incident.
  - Specifically identify who said what and/or who witnessed what part of the incident.
  - List what led up to the incident, other pertinent events occurring at the time, and any contributing acts of friends, relatives, or residents that may have led to the event.
  - Describe any equipment involved.
  - Note any injuries and state what medical care has been provided or is planned.
- iii. Informs the supervisor on the shift of the occurrence. If staff suspects resident abuse, the supervisor must be notified immediately and the Report of Suspected Dependent Adult/Elder Abuse form (SOC341 4/90) must be completed and submitted with the Unusual Occurrence report (refer to



Hospital-wide Policies and Procedure LHHPP 22-01). On the evening, night and/or weekend/holiday hours, notify the Operations Nurse Manager on duty

- iv. Notifies the attending physician if the incident involves the clinical care of a resident.
  - v. Notifies the resident's family or surrogate decision-maker of the incident as appropriate.
  - vi. Submits ~~the UO report~~ other necessary documents to Quality Management Department.
- e.b. The supervisor or Operations Nurse Manager on duty will determine whether immediate additional follow-up or action is required and whether notification of the Medical Director, Division Head, and Administrator on Duty is warranted.
- f.c. If the incident involves a resident, documentation of the event, clinical response, and monitoring activities must be noted in the medical record according to the Hospital-wide Policies and Procedures. Do not document in the medical record the fact that a UO has been completed.
- g.d. ~~The Quality Management (QM) staff will assign Aa~~ unique log number will be assigned to each submitted UO. QM staff ~~then~~ will triage the UOs within 24 hours or the next business day and request for follow-up information as ~~follows~~ necessary using the on-line UO system:

- i. Follow-up and ~~Investigation~~ investigation of non-UO rR Reports:
  - ~~The origin~~ UO notification will be sent to managers, supervisors and other relevant staff. UO, UO follow-up and orR investigation report(s) are sent to requested from managers as appropriate necessary for additional information. to determine contributing factors, corrective actions taken and/or referrals for follow-up actions.
  - The manager and or other relevant staff assigned shall log in to the on-line UO system, review their respective worklist and read the UO report and or messages no later than the second next business day.
  - Completed follow-up ~~reports~~ and/or on-line investigation reports are to be submitted to the QM Department within ~~three (3)~~ four working business days of the UO report.
  - QM staff will track the return of follow-up and orR investigation reports.
  - Staff are required to use the on-line UO system and not use the email system to address case specific UO issues.

ii. Follow-up of rReportable UOs (refer to Hospital Wide Policies and Procedures File 60-03 for a list of reportable events):

- The QM staff will notify the designated Division Head(s) and managers of reportable occurrences and may direct further staff actions.
- Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department no later than the 4<sup>th</sup> calendar day following the incident.

~~Reporting of~~ Telephone notification of reportable Unusual Occurrences to ~~the~~ California Department of Public Health (CDPH) will be made by the Licensing and Certification (L & C) liaison during regular work hours. ~~will be done by the CDPH Licensing and Certification (L&C) liaison who will assure that the appropriate telephone report and letter are complete~~

- ~~d. Copies of all letters sent to CDPH must be placed in the Administrative California Department of Public Health (CDPH) file.~~
- Weekend/Holiday reporting of Unusual Occurrences will be done by the Nursing Operations Manager on duty with notification to the CDPH L&C liaison on the next business day. The CDPH L&C liaison will assure that the required follow-up letter is sent and a copy placed in the CDPH file.
- The L&C liaison will assure that the required follow-up letter is sent and a copy placed in the CDPH file.

~~e. The~~ QM staff will aggregate Unusual Occurrence data to identify patterns/trends. UO summary reports will be brought to the ~~HWPIC-PIPS committee~~ for further review, evaluation, and recommendations (e.g., if patterns/trends are identified, the ~~HWPIC-PIPS Committee~~ may work with the involved departments to institute further studies and develop a plan of correction, which may include a mechanism for ongoing monitoring).

~~h.f.~~ The UO report may be classified as closed by QM staff after sufficient essential information is gathered and corrective action(s) implemented to minimize risk of occurrence.

~~i.g.~~ UO summary reports ~~also~~ will be ~~made~~ submitted to the Medical Executive Committee (MEC) through the ~~HWPIC-PIPS committee~~ and to the Joint Conference Committee. Recommendations from these Committees will be forwarded to the MEC.

### 2.3. Downtime procedure for reporting an Unusual Occurrence

- a. Before the end of the work shift, the ~~reporting employee~~charge nurse, reporting employee, or designee:
  - i. Completes the UO form F-821A (also LHHPP 96-06), Revised 06/00, "Confidential Report of Unusual Occurrence":
    - Complete Part 2 by using the resident's plastic ID plate to imprint the forms. If more than one resident is involved, write additional names in Part 2. If the occurrence does not involve a resident, information must be written in regarding any staff or visitors involved.
    - Complete Part 3 by stating the facts as outlined in Section 2 above.

**ATTACHMENT:**

**REFERENCE:**

LHHPP 22-01 Abuse Protection Program: Prevention, Recognition, Reporting

LHHPP 24-06 Resident Suggestions and Complaints

LHHPP 60-03 Incidents Reportable to the State of California

LHHPP 60-12 Sentinel Events

LHHPP 96-06 Unusual Occurrence Confidential Report

LHHPP 96-07 Unusual Occurrence Follow-up Report

Laguna Honda Form SOC341 (4/90)

Laguna Honda On-line UO Pocket Guide

Revised: 96/07/15, 98/08/10, 00/03/09, 08/01/08, 11/09/27, 15/09/08 (Year/Month/Day)

Original adoption: 94/08/15

## LICENSING AND CERTIFICATION VISITS

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) staff shall coordinate Licensing & Certification (L&C) visits, including the annual licensing and recertification survey, through designated staff from the Quality Management Department who will act as the L & C liaison.

### PURPOSE:

To assure appropriate and consistent actions and to keep Administration informed of ~~all~~ L&C activities on site.

### PROCEDURE:

1. L&C representatives are to be directed to Administration to announce their visit prior to conducting official business.
2. The L&C liaison is to be notified any timewhen L&C surveyor(s) arrives on hospital premises.
3. The L&C liaison will meet with the surveyor(s) to determine the purpose of the visit.
4. The L&C liaison will accompany the surveyors to the appropriate department in which to conduct their investigation and remain with the surveyors if this should be necessary. If the L&C liaison does not remain with the surveyors, the staff working with the surveyors must notify the liaison of ~~all~~ interaction(s) that have occurred with L&C surveyor(s).
5. The L&C liaison will notify appropriate division head(s) and manager(s) of the outcome of the L&C visit and coordinate any necessary follow-up actions.
6. The L&C liaison is responsible for gathering documents requested by the L&C surveyor(s). Documents received must be reviewed for appropriateness by the by the L&C liaison before they are submitted to L&C surveyor(s).
7. Requested documents typically consist of patient/resident medical records, policies and procedures, alleged resident abuse investigation reports, manufacturer instructions, employee personnel records, schedules, activity calendars and Resident Council meeting minutes. Documents or printed material that are confidential and protected under California Evidence Code Section 1157 are not to be submitted to L & C surveyors. Photographs related to Unusual Occurrence reports are considered protected documents obtained for performance improvement activities and are not to be submitted to L & C surveyors.

8. Risk Management Nurses from the Quality Management department are responsible for maintaining a log of complaint investigations conducted by L & C surveyors and keeping a copy of documents submitted to the surveyors.

-

~~5. Any plan of correction submitted to L&C must be signed by the Executive Administrator or authorized designee.~~

**REFERENCES:**

None

Revised: ~~08/01/08~~ 15/09/08 (Year/Month/Day)

Original adoption: 93/10/01

## **EMERGENCY PREPAREDNESS COMMITTEE**

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to implementing an emergency preparedness program that at a minimum includes staff participation at committee meetings to plan, learn, be involved in emergency preparedness exercises, provide feedback on existing procedures and provide recommendations to improve staff performance in emergency response.

### **PURPOSE:**

To maintain a safe environment for residents, staff, volunteers, and visitors, enhance staff awareness and encourage interdepartmental collaboration to optimize staff response to emergency events.

### **PROCEDURE:**

#### **1. Membership**

- a. The Emergency Preparedness Committee (EPC) shall comprise of a representative from every department and neighborhood.
- b. There shall also be staff representation from all 3 shifts.
- c. The Emergency ~~Preparedness Management~~ Coordinator shall serve as the chair of the committee, and an alternate designee assigned as necessary.
- d. Departmental and neighborhood representatives may be selected to represent respective departments or neighborhoods at any time by Department managers to ensure active committee participation and provide new staff the opportunity to learn about responsibilities of the EPC and emergency preparedness activities

#### **2. Meeting**

- a. The Committee shall meet ~~monthly at least ten times per year~~ quarterly six times a year, or more often as the need arises.

#### **3. Minutes**

- a. Written minutes shall be maintained for each meeting and when approved at the subsequent meeting submitted to the Hospital Executive Committee.

#### **4. Responsibilities of Emergency Preparedness Committee Members**

- a. Attend monthly meetings, and designate an alternate attendee if unable to attend.
- b. Assist in maintaining a current departmental or neighborhood staff call back roster.
- c. Provide communication updates to departmental or neighborhood staff on emergency preparedness activities, plans and procedures.
- d. Maintain a current Emergency Preparedness binder in respective departments or neighborhoods.
- e. Participate in internal and external disaster drills at least two times a year.
- f. Collaborate in completing a Hazard and Vulnerability Assessment annually.
- g. Assist in the review, development and implementation of emergency preparedness policies and procedures for process improvement.
- h. Represent Laguna Honda at external disaster preparedness meetings to support and enhance the collaborative efforts of mutually involved city, state and federal organizations as necessary.

**ATTACHMENT:**

None

**REFERENCE:**

LHHPP 77-02 Emergency Preparedness Program

LHHPP 73-01 Injury and Illness Prevention Program (IIPP)

Revised: 95/05/01, 98/11/16, 11/08/29, 13/01/29, 15/09/08 (Year/Month/Day)

Original adoption: 92/05/20

## **EMERGENCY PREPAREDNESS**

### **POLICY:**

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to Emergency Preparedness through a continuous cycle of planning, organizing, conducting training exercises, evaluating processes, and implementing corrective actions.
2. Laguna Honda staff is responsible for participating in training, exercises, and achievement of departmental and hospital-wide goals for emergency preparedness.
3. Employees are provided with a disaster service worker identification badge that mandates city employee presence in the event of a disaster.
4. Staff are responsible for providing their current emergency contact information to the Department Manager and the Human Resources department. Department Managers are responsible for maintaining an accurate call back list.
5. The facility shall utilize the Hospital Incident Command System (HICS) for internal and external communication during emergency incidents and planned events.
6. Communication and coordination with public health and other hospitals city wide is achieved through regular meetings, joint exercises, and coordinated planning.

### **PURPOSE:**

To have staff trained and prepared to respond to emergency situations.

### **PROCEDURE:**

#### **1. Training and Exercises**

- a. New employees are introduced to Emergency Preparedness concepts during their orientation.
- b. Emergency Preparedness in-service is provided at least annually.
- c. Additional training is provided through exercises that include defining and practicing departmental and individual roles with the Incident Command Structure (ICS) and development of next steps based upon exercise evaluation.
- d. Training and department specific goals emphasize continuous home preparedness development and maintenance, including keeping an emergency wallet card with an out of area contact in the event that local telephone service is limited during an actual event.



## 2. Communication and Coordination

- a. Each department and neighborhood has a representative assigned to the Emergency Preparedness ~~Team~~ Committee who is responsible for continuously enhancing and sustaining emergency preparedness by:
  - i. Participating in regularly scheduled meetings and sending an alternative representative if unable to attend.
  - ii. Bringing back key information to the department or neighborhood.
  - iii. Serving as the champion and liaison for the achievement of department-specific and hospital-wide goals.
  - iv. Maintaining a hard copy of Laguna Honda's Emergency Preparedness Manual in each department and neighborhood.
- b. The department manager facilitates continuous updates for the emergency Confidential Call Back Lists. The confidential call back lists are kept securely in the HICS Command Center, ~~cabinets in Room B102 and the Nursing office.~~
- c. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of the ~~Chief Operating Officer~~ Department of Workplace Safety and Emergency Management.
- d. Emergency preparedness updates are communicated at leadership forum, executive, neighborhood and departmental meetings as necessary.
- e. Laguna Honda participates in a city-wide network of coalitions to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.
- f. Multiple communication systems are available and practiced to achieve redundancy in the event of technology downtime and to achieve coordination city-wide, ~~including~~ 800 MHz radios and METS phone (Mayors Emergency Telephone System) are tested monthly. ~~Refer to 70-03 Emergency Response for a list of devices.~~
- ~~g. Designated staff of Laguna Honda practices receiving and acknowledging CAHAN alerts with the rest of the state on the 1<sup>st</sup> Tuesday of every month. 800 MHz radios are tested at the same time.~~

## 3. Re-Assessment and Planning

- a. A Hazards and Vulnerability Assessment (HVA) is completed annually to identify emergency incident risks to drive training and exercise development.

- b. Opportunities to participate in state wide, city wide, DPH wide and other multi-jurisdictional exercises are incorporated into exercise plans each year for a minimum of 2 functional exercises annually, no more than 6 months apart. Real incidents requiring HICS activation can substitute for exercises.
- c. Response plans for the following list of hazards have been developed by the facility and are reviewed annually for performance improvement opportunities:
- i. Earthquake Preparedness
  - ii. Emergency Responder Dispensing Plan (Mass Prophylaxis)
  - iii. Fire Safety
  - iv. Medical Surge
  - v. Water Disruption
  - vi. Power Outage
- d. Emergency Supplies
- i. Emergency supplies are stored in a central location near the HICS command center.
  - ii. An inventory of supplies is kept on the front of the nursing office HICS cabinet and on the inside of the door of the B102 HICS cabinet by the Department of Workplace Safety and Emergency Management.
  - iii. A list of AeroScout tagged equipment (including over 500 items such as intravenous and feeding pumps, gurneys, wheelchairs, suction pumps, vital sign machines, EKG machines, crash carts and AED's) (for quick location of items if computers are functional) is kept in both the Command Center and the Nursing Office HICS cabinets and is updated-maintained by nursing informatics quarterly and. (Includes over 500 items such as intravenous and feeding pumps, gurneys, wheelchairs, suction pumps, vital sign machines, EKG machines, crash carts and AED's.)
  - iv. A 7-day food supply for 14002000 people and water to augment the 600,000 gallons of water in towers behind the 5<sup>th</sup> floor parking lot.
  - v. A par level of linen maintained by the Environmental Services Department.
  - ~~v.~~vi. A cache of antibiotics for Laguna Honda Pharmacy available for delivery from DPH storage sites. (Refer to Appendix H: Hazard Specific Plans –Emergency Responder Dispensing Plan.)

~~vi-vii.~~ Par levels of medical and personal patient care supplies are available through most vendors.

#### 4. Emergency Preparedness Manual

- a. Provides the policy, purpose and procedure for emergency response with appendices for pertinent details.
- b. The manual describes the Hospital Incident Command System (HICS), DPH and LHH organizational structure, and general ~~and departmental emergency response to the list of hazards identified under 3c.~~ emergency response procedures.

#### 5. Personal Preparedness

- a. Staff are encouraged to continuously enhance their personal preparedness.
- b. Key activities recommended include assembling preparedness supplies in a kit at home and as a “Go bag,” and to having a plan noted on a Red Cross Emergency Wallet Card (See Attachment A).
- c. Information and links are provided on the LHH intranet under the “Laguna Honda Emergency Management” button.

#### **ATTACHMENT:**

Attachment A: American Red Cross Emergency Contact Card

#### **REFERENCE:**

LHHPP 70-03 Emergency Response Plan

Most recent review: ~~13/05/28~~, 15/09/08 (Year/Month/Day)

Revised: ~~N/A~~ 15/07/17, 15/09/08

Original adoption: 13/05/28

## PUBLIC ACCESS AND NIGHT SECURITY

### POLICY:

Access to the hospital grounds and buildings is controlled.

### PURPOSE:

To assure a safe and secure environment for residents, staff, and visitors.

### PROCEDURE:

#### 1. General Procedure

- a. The following persons have authorized access to certain Hospital areas and must have identification or issued sticker visible at all times:
  - i. Residents who have been ~~n-duly~~ admitted.
  - ii. Resident's visitors, who have signed in at the pavilion between the hours of 10:00 a.m. and 9:00 p.m., unless the Nursing Operations Manager authorizes special visitation ~~and so notifies~~ after consultation with the neighborhood staff.
  - iii. Employees who are
    - Working during their regularly scheduled work hours,
    - called in to work (on-call, overtime, and emergency), or
    - on-site during their non-scheduled work hours:
      - must (1) report to their respective department offices, (2) state the reason for being on campus and (3) receive permission from an authorized person (department head or designee) to be on-site. The department head is expected to know the purpose, place and duration of the employee's visit.
      - may visit the Human Resource Services or Payroll offices during ~~(non?)~~ business hours.
  - iv. Administrative, management, and supervisory employees in the performance of their job responsibilities.
  - v. Employees visiting a resident, ~~have~~ ~~–~~visitor status and are expected to follow policies and procedures for visitors.
  - vi. Persons (e.g. vendor representatives, peer mentors, students, consultants) with an appointment to conduct official business.
  - vii. Volunteers duly enrolled in the hospitals' volunteer or clergy program.

b. Employees and residents who notice a suspicious package, event or suspicious a s person ~~tranger, especially without a Hospital identification badge in the Hospital~~, shall contact the ~~San Francisco~~ Sheriffs' substation (SFSD) through the operator at 4-2319 for immediate investigation. ~~Give for immediate investigation by giving the operator~~ the following information:

1. Identify yourself
2. Location of incident
3. Activity, what is the incident
4. Number of persons involved
5. Description of the persons involved
6. Danger, are there any weapons.

~~b. your (1) name, (2) location, and (3) a concise description of the individual and/or~~

c. The Administration building is closed between 5:00 p.m. and 6:00 a.m.; ~~and on~~ weekends and holidays. Access to the Administration building during these times is only through employee badge access.

## 2. Night Procedure

a. ~~Sheriff's Staff~~ ~~The SFSD~~ shall secure all perimeter Hospital doors from 56:00 p.m. – 65:00 a.m., and the Pavilion lobby entrance at 9:15pm.

b. Notices posted near all entrances will advise the public that visiting hours begins at 10 a.m. and concludes at 9:00 p.m. ~~Ten minutes before 9:00 p.m., the Telecommunications operator~~ Nursing Office Staff shall make an announcement via the public address system. ~~Visitors who wish to remain after 9:00 p.m. will be asked to notify the Nursing Operations Manager or designee, for express permission that visiting hours are ending. In If Nursing Operations Manager or designee provides express permission, they will notify the SFSD. (None of this is ever done)~~

c. The San Francisco Fire Department can gain emergency access to the buildings by accessing the emergency key located at boxes ~~outside the main entrances to each building~~.

3. All employees shall use designated entrances and exits at night.

~~The SFSD will report an employee's use of unauthorized entrances/exits to the employee's manager for follow-up action. (Not familiar with doing this, or how?)~~

### ATTACHMENT:

None

**REFERENCE:**

None

Revised: 96/07/15, 99/08/05, 12/09/25, 15/09/08 (Year/Month/Day)

Original adoption: 94/08/15

## DISORDERLY OR DISRUPTIVE VISITORS

### POLICY:

Disorderly or disruptive visitors whose presence or activity threatens the health, safety or well-being of others at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) are to be escorted out of the hospital buildings and or grounds by Deputies of the San Francisco Sheriff's Department. ~~Officers of the San Francisco Sheriff's Deputies Department.~~

### PURPOSE:

To provide safety and security for everyone on premises.

### PROCEDURE:

1. Residents' visitors are welcomed between the hours of 10:00 a.m. and 9:00 p.m., and between 9:00 p.m. and 10:00 a.m. if authorized by the ~~Medical Director~~ Chief Medical Officer or designee, Chief Nursing Officer or designee, unit physician or nurse manager/charge nurse, who so notify the unit staff.
2. Residents' visitors are required to abide by Laguna Honda rules that are designed to provide for the safety and well being of everyone on premises.
- ~~2.3.~~ Visitors are to check in with Sheriff's staff at the front lobby of the Pavilion Building. They will legibly write their name, the resident they are visiting, the location, and the time they arrived. The Sheriff's staff will provide the visitor with a sticker with the date and the location they will be visiting. The visitor will wear this sticker on their clothing where it is visible. Every adult visitor will be issued a sticker to wear while visiting on the Laguna Honda Hospital Campus.
4. Whenever a visitor's demonstrated behavior violates Laguna Honda safety policies, staff must notify the ~~San Francisco~~ Sheriff's Department (~~SFSDP~~ at 4-2319 ~~(emergency 4-2999 if there is a threat of immediate physical harm)~~). The caller should :
  - a. Identify yourself
  - b. Location of the incident
  - c. Activity, what is the incident
  - d. Number, number of persons involved
  - e. Description, give a brief description of person(s) involved
  - a.f. Danger, are there any weapons involved.
  - g. REMAIN ON THE LINE.

~~3. should identify their name, describe the visitor (name and or physical attributes and clothing) and the incident, and state the visitor's location to which Sheriff's officer should respond.~~

If a weapon is brandished, or the situation poses potential risk of harm, call "Dr. Gray"

~~4.5. Sheriff's staff~~ The ~~SFSD~~ will conduct a preliminary investigation of the complaint(s) and determine if any crime has been committed. If no crime has been committed, the ~~deputy officer~~ may advise or ~~officially~~ admonish the visitor. If a crime has been committed, the ~~deputy officer~~ will follow established procedures based on the nature, severity (infraction, misdemeanor, felony), and other factors in determining the appropriate action.

~~If the visitor has been asked to leave and if By law, SFSD personnel cannot physically remove or eject visitors. If a the visitor person refuse to leave, and all efforts to encourage that person to leave voluntarily fail, the Deputy Sheriff's Officer may choose to charge the person with violating trespassing on hospital grounds. laws.~~

~~5.6.~~ The ~~Sheriff's Watch Commander~~ ~~SFSD~~ may recommend that problematic persons be prohibited from entering the hospital. This information will be submitted to the Executive Administrator, or designee.

~~7.~~ Visitors with aggressive behaviors, may have restrictions placed upon their visits to the facility. ~~\*\*\* We need to establish a procedure for how aggressive behavior will be communicated\*\*\*.~~

~~6.8.~~ The Deputy City Attorney may be contacted for consideration of a ~~stay away order or a~~ restraining order.

#### REFERENCES:

LHHPP 75-06 Dr. ~~Gray~~ Grey Code

#### Attachments:

SFSD Response Template Calls for Service

Revised: 96/07/15, 10/06/08, 15/09/08 (Year/Month/Day)

Original adoption: 94/08/15



## **STAT CALLS FOR SHERIFF'S ASSISTANCE**

### **POLICY:**

The San Francisco Sheriff's Department (SFSD) will provide an emergency response to "STAT" calls requested by Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) staff for their assistance.

### **PURPOSE:**

To provide ~~guidelines when a code useful in~~ calling for ~~emergency~~ Sheriff's assistance.

### **PROCEDURE:**

1. Call the ~~Sheriff's Office at (4-2319)Operator (4-2999)~~ for assistance and say:

a. ~~We need the~~ "STAT response for Sheriff's assistance",

2. State:

a. ~~Identify yourself your name,~~ Your name

b. ~~Location of Incident the incident location,~~ Incident location

c. ~~Activity what is the~~ Nature of the incident.

d. ~~Number, the n~~ Number of people involved

e. Description of the person/s involved

e.f. ~~Danger, are there any~~ including weapons

Remain on the line.

3. The ~~cadet operator~~ will ~~via the radio~~ dispatch ~~deputies SFSD for~~ immediate assistance.

4. Sheriff ~~Office~~ Deputies ~~yr(s)~~ will respond immediately to the requested incident location.

5. The caller should stay on the line (if possible) to provide critical information to the ~~cadet operator~~ and responding ~~deputies officer(s)~~.

### **REFERENCES:**

None

Attachments**REFERENCE:**  
SFSD Response Template Calls for Service

Revised: 96/07/15, 98/11/16, 02/02/15, 10/06/08, 15/09/08 (Year/Month/Day)  
Original adoption: 93/05/10

## DR. GREY CODE

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall provide a system for employees who are confronted by a potentially violent or dangerous individual to request in an undetectable manner immediate assistance from the San Francisco Sheriff's Department (SFSD).

### PURPOSE:

To provide an appropriate level of safety and security by instituting a coded emergency response for situations involving weapons or other risk of violence or injury.

### PROCEDURE:

1. In situations involving weapons or other risk of violence or injury, any employee can use the code phrase "Dr. Grey" to communicate to ~~Sheriff's staff~~ the Telecommunications Operator, or to any Laguna Honda staff person, in a manner that will not arouse suspicion of the aggressor of the need for immediate assistance from the Sheriff's Dept. SFSD.
  - a. If the employee is able to do so safely, the employee should immediately call the Telecommunications Operator Sheriff's Office at 4-2319 999 and say "please ask Dr. Grey to come to (location)."
  - b. ~~Provide the below information below: as much additional information as possible; to the Telecommunications Operator (number of person(s) involved, description(s) type of weapon, etc.)~~
    - i. Identify yourself
    - ii. Location of incident
    - iii. ~~Activity, what is~~ Nature of the incident
    - iv. Number of persons involved
    - v. Description of the persons involved
    - vi. Danger, are there any weapons.
  - b-c. Provide the above information if doing so will not agitate the individual or escalate the situation. If you cannot give that information directly, say "I cannot talk right now."
  - e-d. If you have indicated that you cannot give information directly, the Sheriff's staff Telecommunications Operator will ask you some questions that can be answered with "yes" or "no."

- i. "Is there a weapon?" if yes,
  - "Is there a gun?"
  - "Is there a knife?"
- ii. "Is there more than one person involved?"

~~d.e.~~ If the individual becomes suspicious about the call, say that Dr. Grey was called to assist.

~~e.f.~~ If the situation prohibits calling the ~~Sheriff' Office Telecommunications Operator~~, the employee should use the code phrase "Dr. Grey" in a sentence to any other employee who might safely go to another location to call the ~~Sheriff's Office Telecommunications Operator~~.

~~f.g.~~ If an employee makes a statement to you using the code phrase "Dr. Grey," note carefully what was said, note anything unusual about the situation (including presence of strangers), go immediately to a secure area and call the ~~Sheriff's Office at 4-2319 Telecommunications Operator~~. Give your name, tell the location of the employee who gave you the Dr. Grey message, and repeat the message exactly as it was given to you.

2. ~~Deputies will be provided with all available information and The Telecommunications Operator shall immediately dispatched the SFSD by radio to the location and provide all available information.~~ The call for "Dr. Grey" will not be announced on the overhead public address system. ~~The Sheriff's staff SFSD will assess the need for additional units to respond San Francisco Police Department (SFPD) as backup and advise as to the type of response and location. SFPD backup????????? What about FOD or us initiating the call to CWB?~~

~~3.~~

~~4.3.~~ A code 33 will be announced on the radio. All persons using the Laguna Honda radio system will remain off the air until ~~the a~~ Sheriff's ~~supervisor Officer Deputy~~ broadcasts a Code 4 (all clear message).

~~5.4.~~ All on-site ~~Sheriff's sworn staff SFSD duty officers~~ shall immediately respond to the location.

~~6.5.~~ Upon arrival, the ~~Sheriff's staff SFSD~~ will assess the situation and take appropriate action that may include but is not limited to:

- a. taking physical action to subdue the subject or maintaining safe perimeter control;
- b. calling for ~~additional units as SFPD backup; ??????????????~~ and

- c. calling for staff assistance (e.g., department head, physician, psychologist, nurse manager, psychiatrist on duty (OD), etc.).

~~7.6.~~ When the situation has been stabilized, a ~~Sheriff's Supervisor officer~~ Deputy will broadcast a Code 4 (all clear) to release the radio channel for normal use.

~~8.7.~~ Documentation:

- a. The employees involved in the incident will complete an Unusual Occurrence report.
- b. The Resident Care Team (RCT) will evaluate the incident and document it as needed in the medical record.
- c. The SFSD will generate an ~~SFPD~~ Incident Report.
- d. The ~~Sheriff's office staff Telecommunications Operator~~ will log the time and nature of the call and the actions taken.

**REFERENCES:**

~~None~~

Attachments:

[SFSD Response Template Calls for Service](#)

Revised: 00/01/08, 10/06/08, 15/09/08 (Year/Month/Day)

Original adoption: 98/09/28

## ANIMAL CONTROL

### POLICY:

Animals at Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) shall not interfere with hospital operations or pose a safety risk to residents, staff, volunteers, or visitors.

### PURPOSE:

To ensure an environment that is safe for all humans and animals while allowing for therapeutic interactions between animals and residents of Laguna Honda Hospital and Rehabilitation Center.

### PROCEDURE:

1. The Activity Therapy Department implements an animal assisted therapy program. The program is operated in such a manner that no animal is left unattended inside the building. ~~The Activity Therapy Department also ensures that animals involved in the program are appropriate and will not pose a threat to anyone within the hospital. The animal assisted therapy program maintains documentation of current vaccination records on all animals involved in the program. Please refer to the Activity Therapy Departmental Policy and Procedure P5 Animal Assisted Therapy~~
2. ~~The animal assisted therapy program maintains relationships with other animal assisted therapy community programs such as the San Francisco SPCA. Visits by other animal assisted therapy programs are coordinated by the Activity Therapy Supervisor responsible for the animal assisted therapy program. The Activity Therapy Department defers to the participating organization ensure that its animals are appropriate and safe and health records and behavioral certificates are maintained in the organization's files.~~
- 3.2. Volunteers wishing to bring their ~~pets (dogs)~~ to the hospital in order to participate in the animal assisted therapy program will be directed to the San Francisco SPCA. ~~The volunteers and their dogs will be required to successfully complete the SPCA dog training class. Those volunteers will then enroll in the SPCA animal assisted therapy program. Visits to Laguna Honda Hospital will be coordinated between the SPCA and the Animal Assisted Therapy program at Laguna Honda Hospital. After successful completion of the training and registration into the SPCA program, the two organizations can coordinate visits.~~
- 4.3. ~~Laguna Honda~~LHH staff may bring their ~~pets (dogs)~~ to the hospital to be used as pet companions. Therapeutic interaction between those animals and the residents of ~~Laguna Honda Hospital and Rehabilitation Center~~LHH is the sole purpose of staff bringing their pets to work. Employee animals may not be brought to work for the

convenience of staff. In order for employees bring their ~~dogs-pets~~ to be used as pet companions the following steps must be completed:

- a. The employee secures written approval from his or her supervisor and the animal must not interfere with departmental operations.
- b. The employee and his or her ~~dog-pet~~ completes a training course from a recognized animal assisted therapy program such as the San Francisco SPCA. The cost of the courses is the responsibility of the employee. The employee must provide documentation to his or her supervisor ~~and the Laguna Honda Hospital Animal Assisted Therapy program.~~
- c. The employee must provide current vaccination records to be kept on file with their supervisor ~~the Animal Assisted Therapy program.~~

~~5-4.~~ All ~~petseats and dogs~~ must be on leash at all times while on hospital grounds ~~(not feral)~~ unless the ~~cat/dogpet~~ has been certified as a therapy animal and only while engaged in therapeutic interactions with residents so that residents can get the full benefit of the therapeutic interaction.

~~6-5.~~ All Laguna Honda staff and/or volunteers must ensure that their animals do not interfere with the operations of the hospital, or the staff /volunteers' ability to perform their duties.

~~7-6.~~ Visitors are allowed to bring in their pet companions to visit residents, but must comply with the leash provision or the animal must be contained in an appropriate cage/container.

~~8-7.~~ Any animal, including animals maintained within the Laguna Honda Animal Assisted Therapy Program, and pet companions that belong to staff, volunteers, or visitors that is deemed to be a safety concern or not in compliance with hospital policies shall be removed from the hospital.

~~9-8.~~ Visitors, staff or volunteers who do not comply with the leash provision or cage/container will not able to bring their animal into the hospital. If the visitor does not comply, they will be asked to leave and/or the Sheriff's Department will be called.

~~10-9.~~ Staff, volunteers, or visitors assume all responsibility for any liability or damage caused by their animal.

~~11-10.~~ Staff must complete an Unusual Occurrence report and submit to the Quality Management Department in the event of injury on hospital grounds which is related to a pet or to a feral animal. Medical evaluation and treatment of residents, staff, or volunteers in facilities per applicable hospital policy.

~~12.11.~~ Those residents who desire to keep a pet animal on the premises must first obtain permission from their Resident Care Team ~~and Animal Assisted Therapy staff~~. The acceptance of resident pets living at Laguna Honda Hospital and Rehabilitation Center will be evaluated on a case by case basis.

- a. The resident must assume full responsibility for the care, feeding, behavior, health (vet visits), costs and cleaning of all excrement of their animal.
- b. The resident must provide initial documentation of health, appropriate immunizations and evidence of periodic veterinary examinations when requested.

~~13.12.~~ The feeding of non-domestic (feral) animals is discouraged. Reports of resident noncompliance will be forwarded to the resident's Resident care Care team Team. Reports of staff ~~of or~~ volunteer noncompliance will be forwarded to the appropriate supervisor.

~~14.13.~~ Anyone finding a dead animal must notify the Environmental Services (EVS) Department between the hours of 7:00 a.m. and 12:00 a.m. During off hours, the report is made to the Nursing Office ~~which who~~ will contact Environmental Services Department to arrange animal disposal.

~~15.14.~~ Anyone finding an injured animal on hospital grounds shall will attempt to locate the owner if appropriate or contact Animal Care and Control for pick up call the Activity Therapy Department who will make an assessment of the animal's condition and contact the appropriate agency such as San Francisco Animal Care and Control. If the Activity Therapy staff is unavailable, the Nursing office will be notified and personnel with that office will contact Animal Control and Care. If the owner of an injured animal can be identified, that individual is responsible for the animal's care.

#### REFERENCES:

~~LHHPP Hospital Wide Policy and Procedure~~ [28-02 The Farm and Therapeutic Garden](#)  
[Activity Therapy Departmental Policy and Procedure](#)  
[P5 Animal Assisted Therapy](#) ~~None~~

Revised: 10/12/01, 15/09/08 (Year/Month/Day)

Original Adoption: 92/05/20



## 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.

b.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. A signature card (index card) for each student must be completed and submitted to Health Information Services (HIS), even if they are not to chart, with the following information along with notification to HIS on whether the students will only read the charts or will write or dictate in the charts.~~

~~a. Full printed name~~

~~b. Title~~

~~c. Name of school~~

~~d. Time frame at Laguna Honda~~

~~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~~

~~9.8.~~ Dictations and / or medical record entries by students need to be counter-signed by the Laguna Honda on-site supervisor.

~~10.9.~~ 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")

~~11.10.~~ 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.

~~12.11.~~ Students may not enter No PHI may be entered onto their personal a-lap-top, blackberry or other electronic device(s). without specific clearance from the Information Services department. When such clearance is granted, the device must be encrypted and kept in the owners possession at all times, according to the DPH Data Security policies.

~~13.12.~~ Resident's PHI is not to be included in email messages to or from affiliating students or faculty.

- ~~14-13.~~ 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.
- ~~15-14.~~ 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.
- ~~16-15.~~ 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.
- ~~17-16.~~ Computer access to information is subject to the DPH HIPAA policies and facility policies.
- ~~18-17.~~ Laguna Honda departmental site coordinators act as liaisons to evaluate placement and facilitate resolution of issues that may arise.
- ~~19-18.~~ 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.
- ~~20-19.~~ 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.
- ~~21-20.~~ Student volunteer policies are addressed separately within the Laguna Honda Volunteer departmental policies and procedures.

**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](#)  
Original adoption: 11/09/27

**Laguna Honda Hospital  
Infection Control Manual**

SECTION C: Hospital-Wide Policies

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TITLE: **DISPOSABLE MEDICAL SUPPLIES**

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Purpose:

In order to ensure that single use disposable products are used properly to avoid transmission of microorganisms to other residents.

Statement of Policy:

It is the policy of the Infection Control Committee that single use disposable items such as syringes, needles, suction tubing, Foley catheters, shall be used once and then discarded into an appropriate waste disposal system.

Procedure:

Consideration of shifting to disposables in an area where the item was formerly reusable can be submitted to the Infection Control Committee for evaluation of the Infection Control aspects of the problem.

INVISION RACE and MULTI RACE FIELDS Efft. 2014

OSHPD has revised their reporting requirements for reporting Race and Ethnicity. Based on OSHPD reporting requirements, Hispanic will be reported as an ethnicity. This will be the first question asked to all of our new patients. We will also be able to collect up to 3 races for our multi-racial patients.

New fields have been added to the Invision Registration and Admission Screens to collect the required information:

1. **Hispanic Origin/Descent: (New)**
2. **Race (Up to 3 Races can be collected/NEW)**
3. **Multi Race**
4. **Ethnicity**

The screenshot shows the 'Register Outpatient' screen in the INVISION2 - RUMBA Mainframe Display application. The window title is 'INVISION2 - RUMBA Mainframe Display' and it includes a menu bar with 'File', 'Edit', 'View', 'Connection', 'Transfer', 'Options', 'Tools', and 'Help'. The main content area is titled 'Patient Demographics' and 'ELIGIBILITY' with a date of '07/17/14' and a time of '1205'. The patient's name is 'TEST' and their DOB is '01/01/1960'. Other fields include Sex: F, MRN, and Pt No. The address is '1001 Potrero'. There are fields for Homeless (n), Zip, City, County, State, Oth Loc, Country, Hm Phn, Alt Phn, and Use. The SSN is '000 - 00 - 0001'. Birth information includes 'ca', 'His Origin/Descent', 'Race', 'Mit Race', 'Ethn', 'Lang', and 'Rel'. Marital and Family Size are also indicated. Resident Sts, ID/DL, VA Sts, Service Connected, Organ Donor, and Transgender status are shown. An 'EMPLOYMENT' section follows with fields for Emp, Contact, Addr, Zip, City, State, Country, Phn, Ext, Income Source, Gross Monthly Income, and Liquid Assets. At the bottom, there are function keys: 'PF12 Rev Pt ID', 'PF13 SLID SCALE', and 'PF16 HOMELESS'. A message 'E0400: AT CURSOR POSITION - FIELD IS REQUIRED' is displayed. The Windows taskbar at the bottom shows the system is 'Ready', running 'APL', with 'NUMFLD' and 'TVIYB0NV' processes, and the time is 12:09:19 PM.

**Hispanic Origin/Descent: (New)**

HISPANIC ORIGIN/DESCENT HELP SCREEN

?HISPAN

07/23/14

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OSHPD REQUIRES A FURTHER QUESTION FOR REPORTING A PATIENTS ETHNICITY.

ASK THE PATIENT "ARE YOU OF HISPANIC ORIGIN OR DESCENT"?

THE ALLOWABLE VALUES ARE:

D - DECLINED TO SPECIFY

H - HISPANIC OR LATINO

N - NOT HISPANIC OR LATINO

U - UNKNOWN

**Race – There are some changes on how OSHPD reports Race. To comply, Invision now requires asking if our patients are of Hispanic origin or descent first. Then all patients can further identify with the available racial groups below.**

RACE DESCRIPTION

1 WHITE - A PERSON HAVING ORIGINS IN EUROPE, THE MIDDLE EAST OR NORTH AFRICA

2 BLACK OR AFRICAN AMERICAN - A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA

3 OTHER RACE - PERSON HAVING ORIGINS NOT PROVIDED AS ANOTHER RACE CODE.

5 ASIAN - A PERSON HAVING ORIGINS IN THE FAR EAST, SOUTHEAST ASIA OR THE INDIAN SUBCONTINENT INCLUDING CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM

6 AMERICAN INDIAN/ALASKAN NATIVE - A PERSON HAVING ORIGINS IN NORTH OR SOUTH AMERICA (INCLUDING CENTRAL AMERICA) AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT

7 NATIVE HAWAIIAN/PACIFIC ISLANDER - A PERSON HAVING ORIGINS IN HAWAII, GUAM, SAMOA OR OTHER PACIFIC ISLANDS

D DECLINE TO SPECIFY: VALUE IS NOT ALLOWED IN MULT RACE FIELDS.



**Multi Race: Users can now report on Multi-Racial. The first field is used to report whether the patient is multi-racial**

THIS FIELD INDICATES WHETHER THE PATIENT IDENTIFIES AS

MULTI-RACIAL. ALLOWABLE VALUES ARE:

"Y" - MULTI-RACIAL

"N" - NOT MULTI-RACIAL

"U" - UNKNOWN

**Then we can collect 2 additional Races – Total of 3 Races for Multi-Racial patients**

RACE DESCRIPTION

1 WHITE - A PERSON HAVING ORIGINS IN EUROPE, THE MIDDLE EAST OR NORTH AFRICA

2 BLACK OR AFRICAN AMERICAN - A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA

3 OTHER RACE - PERSON HAVING ORIGINS NOT PROVIDED AS ANOTHER RACE CODE.

5 ASIAN - A PERSON HAVING ORIGINS IN THE FAR EAST, SOUTHEAST ASIA OR THE INDIAN SUBCONTINENT INCLUDING CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM

6 AMERICAN INDIAN/ALASKAN NATIVE - A PERSON HAVING ORIGINS IN NORTH OR SOUTH AMERICA (INCLUDING CENTRAL AMERICA) AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT

7 NATIVE HAWAIIAN/PACIFIC ISLANDER - A PERSON HAVING ORIGINS IN HAWAII, GUAM, SAMOA OR OTHER PACIFIC ISLANDS

D DECLINE TO SPECIFY: VALUE IS NOT ALLOWED IN MULT RACE FIELDS.

ETHNICITY IS A MORE DETAILED BREAKDOWN OF THE PATIENT'S RACE/ETHNIC ORIGIN.



## **CENTRAL SUPPLY STOREROOM INVENTORY SECURITY**

### **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 master keys that access CSR; all 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 Nursing access to urgently required medical supplies and equipment during the hours that CSR is closed.
3. To provide Nursing 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 Logsheets
- 4.4 CSR Inventory Security Agreement

**REFERENCE:**

None

Original adoption: 7/31/15

# Materials & Equipment Logsheet

Name:		Date:		Time:			
Item #	Short Description:	Qty Taken:	Unit of Measure (each, box, pack, roll)	Department Charged to			
e.g. 1305	e.g IV Solution 0.9 NAACL 25ml minibag	2	Packs	North 4			

**Example:**

1305	IV SOL 0.9 NAACL 25ML
010201	MINIBAG
Mfr:	CS 12 PK* 4 BG BAXTER HEALTHCARE CORPORATION

**Item Number ->**

**<- Item Description**

## **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 will 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 CSR is secure when I leave.

User Print Name: \_\_\_\_\_

User Signature: \_\_\_\_\_

Department: \_\_\_\_\_

Date: \_\_\_\_\_

Contact Information for Nutrition Services Staff

<u>Name</u>	<u>Position</u>	<u>Desk Phone ext.#</u>	<u>Pager #</u>
Cecconi, Loretta	Chief Dietitian	4-3367	2533
Kataria, Sheetal	Dietitian	4-3362	1086
<ul style="list-style-type: none"> <li>• N6 (Cypress- 20's&amp; Juniper- 30's)</li> <li>• S4</li> </ul>			
Kearney, Tiffany	Dietitian	4-3395	0994
<ul style="list-style-type: none"> <li>• S2</li> </ul>			
Lai, Julie	Dietitian	4-3340	2327
<ul style="list-style-type: none"> <li>• N3</li> <li>• N6 (Cedar -10's &amp; Redwood- 40's)</li> </ul>			
Langvardt, Mary Ann	Dietitian	4-3097	2328
<ul style="list-style-type: none"> <li>• NM</li> <li>• N4 (Cypress-20's &amp; Juniper-30's)</li> </ul>			
Podesta, Danielle	Dietitian	4-4589	0514
<ul style="list-style-type: none"> <li>• S3</li> <li>• S6</li> </ul>			
Shiels, Rebecca	Dietitian	4-3356	7502
<ul style="list-style-type: none"> <li>• N2</li> </ul>			
Siragusa, Gabrielle	Dietitian	4-3367	1705
<ul style="list-style-type: none"> <li>• PM-Rehab SNF/Acute(rms 48-51)</li> <li>• N4 (Cedar-10's &amp; Redwood-40s)</li> </ul>			
Wildman, Clair	Dietitian	4-3020	7814
<ul style="list-style-type: none"> <li>• S5</li> <li>• N1 (Cypress – 20's &amp; Juniper – 30's)</li> </ul>			
Diet Techs will assist with MDS, screening & QR's as assigned by RD			
Schoenwetter, Andrew	Diet Tech	4-4031	5598
<ul style="list-style-type: none"> <li>• S2, S3, CBORD/menus</li> </ul>			
Subia, Adam	Diet Tech	4-4623	7759
<ul style="list-style-type: none"> <li>• PM, N4, S6, S5, S4</li> </ul>			
Wan, Elisa	Diet Tech	4-3087	1538
<ul style="list-style-type: none"> <li>• N6, N5, N3, N1, NM</li> </ul>			
Diet Office		4-5776	



## **XIX. Use of Pressure Washers**

**POLICY:** The Environmental Services Department (EVS) will comply with all local, state, and federal safety and environmental regulations associated with the use of pressure washers.

**PURPOSE:** To ensure that employees using pressure washers are trained on the proper use of such equipment, that employees are equipped with the appropriate personal protective equipment (PPE), and that Laguna Honda Hospital and Rehabilitation Center (LHH) is in compliance with applicable environmental regulations.

---

### **PROCEDURE:**

The use of pressure washers is necessary to clean several outdoor areas of LHH. In order to ensure the safety of employees, any staff that works with pressure washers is required to follow the procedures outlined in this policy.

#### **A. General Requirements**

1. A hazard assessment of the power washing procedure will be performed by EVS supervisors and/or LHH health and safety staff periodically to evaluate the requirements and effectiveness of PPE used. The evaluation can be conducted as part of ongoing safety audits and inspections. PPE will be purchased and approved by the EVS department. Employees are required to use only approved PPE. PPE shall provide protection against anticipated hazards and employees shall receive training on its proper use. Training for each employee that use pressure washers must include the following:
  - a. When PPE is necessary
  - b. What PPE is required
  - c. How to properly don, remove, adjust, and wear approved PPE
  - d. The limitations of PPE
  - e. The proper care, maintenance, useful life, and disposal of PPE
2. PPE training will be provided by EVS supervisors and/or LHH health and safety staff.

#### **B. Personal Protective Equipment**

1. PPE shall include the following and all must be worn when pressure washing:
  - a. Protective clothing – high visibility rain jacket
  - b. Eye and face protection – safety eyewear includes goggles or close-fitting safety glasses with side shields. Eyewear must comply with ANSI Standard Z87 (normal prescription eyewear do not meet this standard). Face protection includes a face shield. Both eye and face protection must be worn when pressure washing. Employees may not choose between eye or face protection.
  - c. Hand protection (optional) – padded gloves or nitrile gloves. The use nitrile gloves are necessary only if a chemical washing solution is used.
  - d. Foot protection – non-slip boots designed to protect ankles, soles, and toes
  - e. Hearing protection – in the form of ear plugs or ear muffs
2. All PPE will be stored alongside the pressure washer equipment in a clean environment. If any of the above mentioned PPE is missing or damaged, do not start pressure washing operations. Inform your supervisor regarding any missing or damaged PPE.

3. All non-disposable PPE (i.e. rain jacket, eye and face protection, gloves, and boots) will be cleaned and disinfected prior to storage (PPE should also be cleaned prior to use). Any PPE that has been damaged (e.g. torn, ripped, deteriorated, etc.) will be disposed of. Inform your supervisor to any damaged PPE so that it can be replaced.

**C. Area Security**

Pressure washing operations can render floor surfaces to be wet and slippery. In order to prevent slip/trip/fall injuries to staff and residents, affected floor surface areas will be cordoned off by the use of cones, warning signage, and/or caution tape. Do not start pressure washing operations until the perimeter of affected areas are secured.

**D. Environmental Protection**

1. Prior to commencing any power washing activity, survey the work area and locate any storm drains where wash water may flow into. California regulations prohibit any wash water from flowing into storm drains as they can empty into public water bodies. If there is the potential for wash water to flow into storm drains, place storm drain barriers or covers around all affected drains. When nearby storm drains are blocked, water may flow into storm drains that are located away from the immediate work area. Be sure to understand where wash water will flow and block storm drains as necessary.
2. Storm drain barriers and covers are reusable. Clean any used barriers with water prior to storage. Storm drain barriers should be stored with the power washer equipment and PPE.

## **XX. CUBICLE CURTAIN AND DRAPE REPLACEMENT**

**POLICY:** It is the policy of the Environmental Services Department to remove and replace cubicle curtains and drapes as needed.

**PURPOSE:** To ensure all cubicle curtains and drapes are kept clean.

---

### **EQUIPMENT:**

1. Caution Sign
2. Clean Cloths
3. Clean Curtains
4. Equipment required for changing a specific type of curtain
5. Step Ladder

### **PROCEDURE:**

- A. Replace the curtains and draperies anytime they become soiled or after isolation to prevent cross contamination. Place the dirty curtain or drape in a bag according to hospital policy and give to the Laundry for cleaning.
- B. Post the caution sign and set up the step ladder. Ensure that the ladder is on a level surface and that it is locked open before climbing on it.
- C. Remove all hardware and hooks and replace them on the track or set aside for use with the new curtain.
- D. Insert new hooks in the clean curtain, being careful to keep the new curtain off the floor.
- E. Wipe the track ledges with a clean damp cloth prior to hanging the new curtain.
- F. Hang the new curtain and ensure it is working properly.

## **XXI. RAG OUT PROCEDURES**

**POLICY:** It is the policy of the Environmental Services Department to handle and store rag out linen in a safe manner.

**PURPOSE:** To ensure safe handling and storage of rag out linen that are no longer in use by the hospital.

---

### **PROCEDURE:**

- A. All linen deemed unserviceable by the vendor will be laundered, separated, and returned to LHH in separate packaging for inspection and/or disposal.
- B. This linen should be packaged and identified as "ragout" so that the Laundry Supervisor or designee will know that it is unserviceable. Contractor must submit a monthly ragout report by the fifth day of each month.
- C. Ragout linen must be covered in a plastic bag when delivered to the hospital.
- D. Receiving EVS supervisor will store ragout in safe storage.
- E. The ragout report should identify the quantity of ragout by type of item laundered, and indicate the percent of ragout of each type of item. This report will be submitted to the Location Laundry Manager, whose address will be provided.

## **XXI. EVS TEMPORARY SERVICES**

**POLICY:** The Housekeeping Department will clean and maintain all areas of the hospital as required of the hospital standards.

**PURPOSE:** Temporary services may be required in emergency situations above the EVS scope of Work.

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### **TEMPORARY PROTOCOL FOR GALLEY SERVICE CLEANING**

#### **MATERIALS:**

- Mop Bucket
- Mop Handle/Wringer
- Virex 256
- Wet floor sign/caution floor sign
- Broom
- Dustpan
- String Mop
- Appropriate PPE (gloves)

#### **PROCEDURE:**

- A. Check soap and paper towel dispensers and refill as needed.
- B. Empty out trash, recycle, and compost bins by tying off bag and removing bag. Wipe off interior and exterior of wastebasket with damp cloth dipped in germicidal disinfectant solution as needed. Reline empty wastebasket with plastic bag liner
- C. Transport bags by using mobile trash bin every 30 minutes from start of sanitation process. Mobile trash bin is provided and is used to transport trash, compost, and recycle.
- D. Assemble equipment – one clean string mop, mop bucket and wringer, broom, mop handle, dustpan.
- E. Fill mop bucket with germicidal disinfectant solution (Virex 256).
- F. Take equipment to Galley.
- G. Move movable items (trash bins, etc.) to center of room.
- H. Sweep floor with broom. Sweep floor from back to front including under the cabinets.

- I. Sweep debris to door and deposit into garbage bag using dustpan.
- J. Place caution wet floor sign by the door.
- K. Damp mop floor with germicidal disinfectant solution (Virex 256) from back to front using string mop.
- L. Allow floor time to dry before removing caution wet floor sign.
- M. Return movable items (trash bins, etc.) in its proper place.
- N. Use new string mop for every galley. Use new germicidal disinfectant solution before cleaning of next galley
- O. Return to Porter's closet and clean equipment. Put dirty string mops inside dirty mop bin inside the dirty utility room.
- P. Return mop bucket/wringer, mop handle, broom, and dustpan to EVS storage closet.

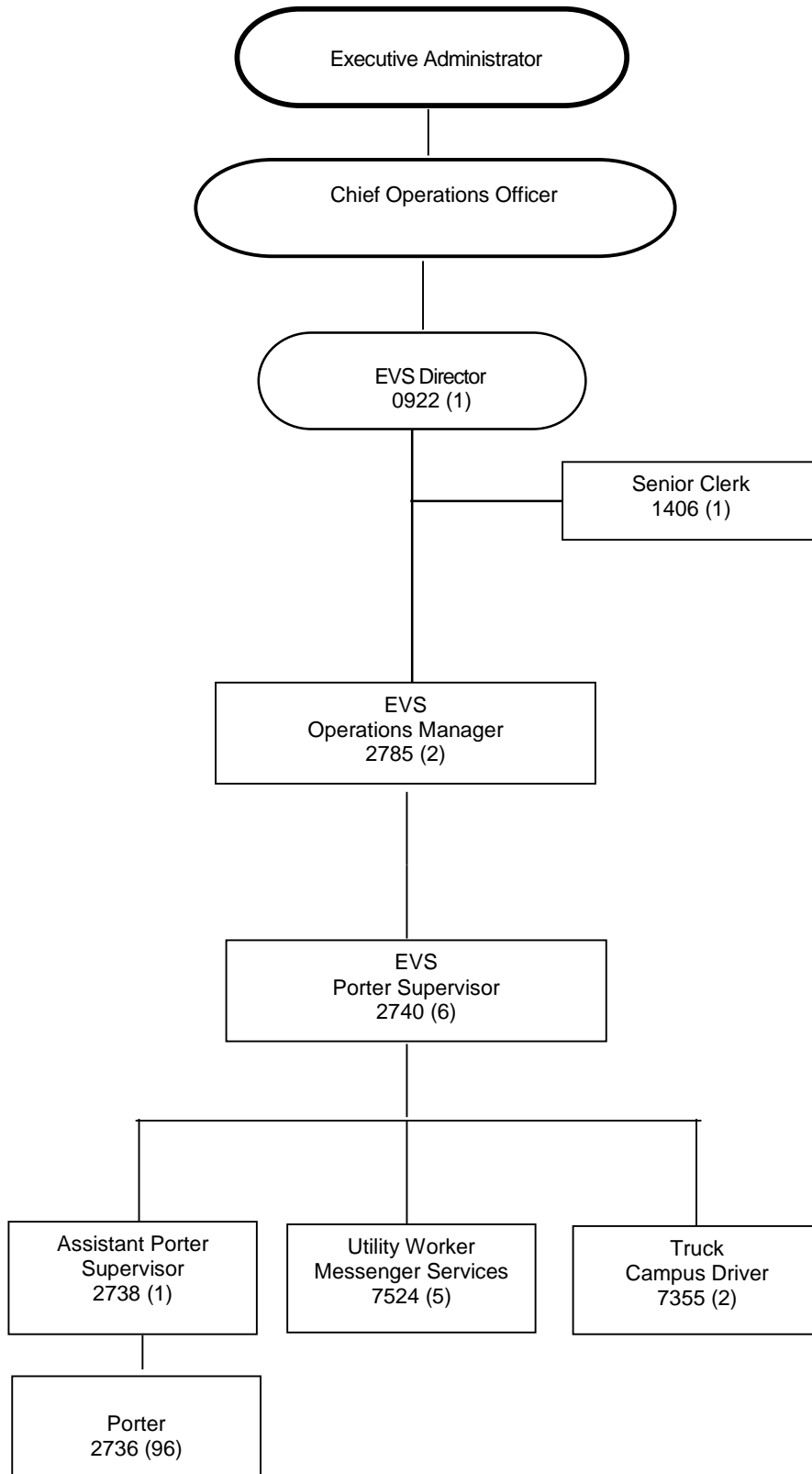
### **GALLEY SEQUENCE**

North 6, South 6, North 4, South 4, North 2, South 2

### **CLEANING TIMES**

- After Breakfast: 10:00am
- After Lunch: 3:00pm
- After Dinner: 9:00pm

### III. ENVIRONMENTAL SERVICES ORGANIZATION CHART

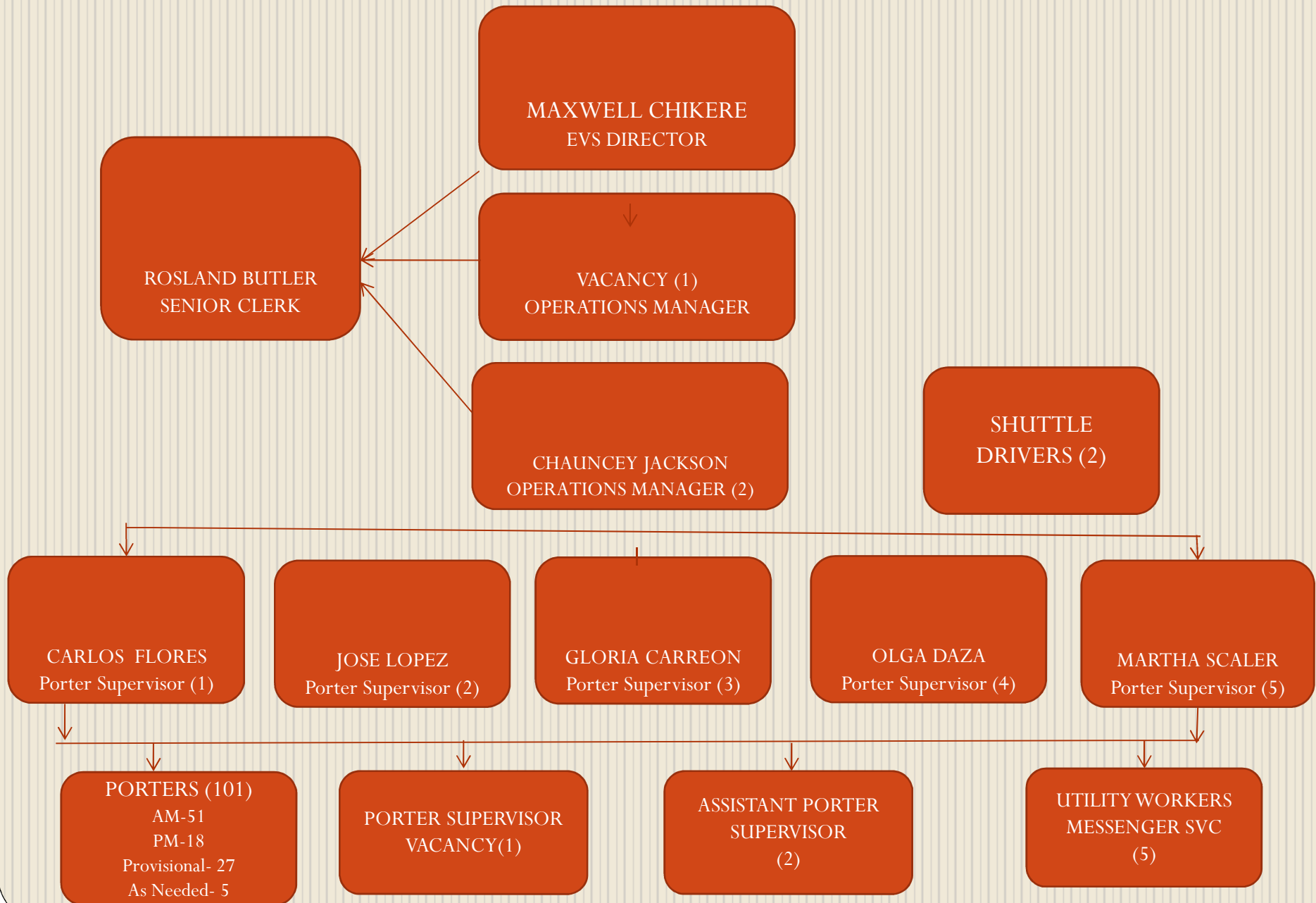


### **A. Organizational Chart Breakdown**

1. EVS Director – Reports to Associate Administrator of Operations and Clinical Support. This position is responsible for overall management of the department.
2. EVS Operations Manager – Reports to Environmental Services Director and acts as his/her representative in/her absence. Assists Environmental Services Director in management of the department.
3. Porter Supervisor – Reports to Operations Manager. Responsible for shift operations or a large segment of shift operation of the Environmental Services Department.
4. Assistant Porter Supervisor – Reports to Porter Supervisor. Responsible for a small segment of shift operations or a particular area. May assume duties of a Porter Supervisor in his/her absence. May also assume the duties of a Porter.
5. Porter – Reports to Assistant Porter Supervisor and/or Porter Supervisor. Responsible for maintaining an assigned area of the Hospital utilizing basic housekeeping techniques.
6. Truck Driver & Institutional Utility Worker – Reports to Porter Supervisor or his/her designee. Responsible for driving of vehicles and performing other utility functions in the Hospital.



# EVS DEPARTMENT ORGANIZATIONAL CHART



#### **XIV. MAIL ROOM PROCEDURE**

##### **PURPOSE**

To provide guidance for LHH mail systems and the handling of Resident mail / packages.

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##### **A. LOCATION AND SECURITY**

The Hospital's mail distribution outlet is located at the H - Wing "Mail Room". The doors to this area are equipped with trilogy lock and can only be accessed by authorized users.

##### **B. DAYS OF SERVICE**

Mail Services are provided six days per week, 12:30 pm to 4:30 pm (Monday through Saturday) except legal Holidays.

##### **C. SOURCES OF MAIL**

1. Downtown (City Hall & other government agencies – brought in by the messenger) to H – Wing.
2. Post Office (Taraval Station – brought in by the messenger).
  - a. Weekdays Mail: Delivered by the messenger to H - Wing Mail Room.
  - b. Weekend Mail: Delivered by Post Office to PBX, sorted and distributed by designated EVS staff.
3. Internal mail brought in from other departments.

##### **D. STAFFING**

The Environmental Services Department will staff the Mail Room from 12:30 pm to 4:30 pm Monday through Saturday except holidays. In the absence of the regular delivery staff on Saturday, the Telecommunications staff on duty will sort resident mail only and deliver as specified.

##### **E. MAIL SORTING PROCEDURE**

- a. Messenger brings in mail from in-house and outside box into Mail Room.
- b. Mail addressed to residents, with named neighborhood/household, named employee with specified household/unit.
- c. To Mail Boxes/Slots: Mail addressed to department, department head title, department head name, employee name, mail for distribution to all mail boxes (as instructed.)
- d. Mail received in the Mail Room must be date stamped before delivering to the resident mail slots.

##### **MAIL TYPE**

Admission and Eligibility (A&E) Mail Box:

- a. Employee name c/o A&E
- b. Admission & Eligibility (A&E)
- c. LHH for patient name/LHH c/o patient name
- d. Patients Utility Bills addressed to resident name
- e. Ambulance Bills addressed to resident name
- f. SF Chronicle Bills addressed to resident name
- g. Insurance bill from CIGNA, Blue Cross, Tricare, Blue Shield, SFGH, etc. addressed to resident name c/o LHH
- h. Medicare Summary notices CMS, HCFA addressed to LHH for resident name
- i. Social Security Administration addressed to patient name c/o LHH
- j. Department of Human Services addressed to patient name w/ LHH address
- k. Other mail addressed to LHH only.

**Residents Mail**

- a. Mail addressed to resident/patient name with LHH plus street address. (To be sorted according to neighborhood, household, or unit.

**Patients Account Mail**

- a. Mail addressed to Patients Accounts or to staff c/o patients account.
- b. Resident's checks addressed to residents from NHIC – National Heritage Insurance Co. (Blue envelope).
- c. Checks (brown window envelope) from United Government Service, LLC window address showing "Pay to the order of – Residents name with LHH address.
- d. Envelope from SEIU, EDD addressed to residents name with LHH address.

Checks (to determine a mail with check, envelope is usually blue, brown color, some in window envelopes, "pay to the order" is mostly shown outside the envelope.)

- a. Checks addressed to or pay to the order of the patient name with LHH addressed deliver to Patient Account.
- b. Checks addressed to LHH from State Controller - medium brown envelope deliver to Patient Billing.
- c. Checks addressed to LHH (in small brown envelope) from State Controller addressed to LHH deliver to Medical Records or HIS.
- d. Checks addressed to department go to corresponding department, e.g. Volunteers, Accounting, etc
- e. Checks in big brown window envelope addressed to LHH from CA State Controller deliver to Accounting.

**Mail Returned to Sender**

- a. Mail addressed to employee – no longer working with LHH. If sender pertains to department function, send mail to that department.
- b. Mail addressed to patient – no longer resident of LHH. Mail addressed to patient from government agencies to be sent to A&E.

**Unidentified Mail**

- a. Mail addressed to LHH with no department name, no department title, and no resident/employee/other name to A&E. If sender is related to patient function, mail goes to A&E, mail related to department function – goes to corresponding department.
- b. Mail returned to sender and the sender's name is only LHH plus the address - mail room clerk can open the mail and write/stamp "opened for routing."
- c. Returned mail from in-house and sent back to the H – Wing Mail Room – mail room clerk can open the mail and write/stamp "opened for routing".

**F. Delivery Procedure:**

- a. Residents' mail will be sorted and delivered in mail slots in H – Wing per household, Neighborhood or Unit.
- b. Resident's packages (large package) delivered to the nurse's station in neighborhood.
- c. LHH doctors' mail to be delivered inside Medical Director's Office Room (only authorized personnel with id. Access).
- d. Deliver mail to Administration (1st floor) which includes: Administration/personnel, Deputy City Attorney, Laguna Honda Foundation/personnel. Take out the outgoing mail from the box, sort mail in H – Wing mailroom.
- e. Nursing Administration mail to the nursing office mail slot.
- f. All MD's, Psychologist's (Ph.D. and PsyD.) mail to Medical Director's Office.
- 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.

Back to Mail Room

- a. Again, sort mail from in-house box, and all other unsorted mail. Leave the keys to EVS box (Box #50).

## **XVI. ICE MACHINE & REFRIGERATOR CLEANING**

**POLICY:** The Housekeeping Department will clean and maintain machines and refrigerators in a sanitary condition.

**PURPOSE:** To prevent the spread of bacteria by removing breeding grounds such as food substance, finger print, hard water stains, rust, mold and mildew.

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### **PROCEDURE:**

#### **Daily:**

- a. Put on hand gloves and other protective equipment.
- b. Use MikroKlene (25 ppm) to sanitize and clean exterior of ice machine by using the three bucket method.
  1. **Cleaning Procedure (Green Bucket):** Mix the detergent, Cleanforce Tuff Suds at the proper dilution of 1 oz. per gallon of hot water is used to remove any surface dirt. Apply clean cloth. Change after 30 minutes.
  2. **Rinse Procedure (Blue Bucket):** Thoroughly rinse all surfaces being cleaned with the warmest water available, using another clean cloth. Change after 30 min.
  3. **Sanitizing Procedure (Red Bucket):** Fill sanitizer bucket with 3 qt. MikroKlene solution from dispense. Apply with clean cloth to all surfaces previously cleaned. Allow all food contact surfaces to air dry-no potable water rinse required. Change after 2 hours.  
**If dispenser are not working, follow the emergency back up plan.**

#### **Weekly:**

- a. Perform above procedures.
- b. Polish stainless steel panels if needed.

#### **Materials:**

- MikroKlene
- 3 Bucket
- Clean Rags
- Hand Gloves

**Note: Outbreak of infection: Use Infection Control guidelines such as bleach solutions to wipe clean all surfaces.**

Adopted: August 2015

Previous Revision: May 2009, August 2013

## STANDARD PRECAUTIONS ~~BODY SUBSTANCE ISOLATION~~ POLICY

SUBJECT: Facility Services Departmental Standard Precautions ~~Body Substance Isolation~~ Policy

POLICY: The Facility Services department shall abide by the procedures set forth for the LAGUNA HONDA HOSPITAL STANDARD PRECAUTIONS ~~BODY SUBSTANCE ISOLATION~~ and HAND HYGIENE P&P's.

PURPOSE: To assure that work performed by the department conforms both to the procedures described with within the Standard Precautions ~~Body Substance Isolation~~ P & P, and that trades/crafts persons that observe body substances or unknown substances on surfaces during the course of the work shall report it for removal prior to engaging in work.

PROCEDURE: ~~The hand washing admonition is repeated to emphasize the critical role which proper hand washing performed at the appropriate time has on the overall infection control program at a hospital.~~

1. Gardeners: Gardeners perform work in all the cultivated areas on premises while maintaining gardens adjacent to buildings and removing debris from their working areas, using a variety of cutting tools, including but limited to mowers, trimmers, saws, and knives.

~~Precautions: As a general practice for all crafts persons, regular hand hygiene washing must be done both before and after working in patient care areas as well as subsequent to contact with articles which may be soiled with body substances.~~

Gardeners should wear gloves when handling anything wet or visibly soiled by body substances. The choice of gloves should be appropriate to the type of articles being handled. Therefore, heavy gloves should be worn when handling sharp objects. Gardeners should take care in handling of needles and other sharps, which must be disposed of in puncture-proof containers.

2. Plumbers: Plumbers maintain the water supply and waste systems. Most of this work will occur in the residents' bathroom areas, while other work is required in the steam plant, underneath buildings, and to the gardeners' watering system. During the course of regular work, plumbers come into contact with patients'

bathroom toilets, basins, urinals, tubs, floor drains, bed pean flushers, utility sinks, and shower roomss, ~~as well as nursing station plumbing fixtures such as the toilet and wash basins.~~ Additionally plumbers come into contact with laboratory sinks and drains in the clinics and surgery areas, and housekeepers' sinks throughout the hospital as well as water fountains in the corridor. Plumbers perform numerous repairs on kitchen cooking preparation equipment, the dishwasher machines, sinks and floor drains ~~in the butcher shop~~, and much work involves —the use of metallic tools and equipment. Plumbers may receive small cuts and bruises while working.

~~Precautions: As a general practice for all crafts persons, regular hand hygienewashing must be done both before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.~~

Plumbers should wear gloves, an appropriate mask, and eye protection when working in situations where splashing of body substances is likely to occur. The plumber should wear additional protective covering over clothes and hair in cases where splashing of large quantities may occur.

Plumbers should wear gloves if contact with body substances are likely, but splashing is not expected.

3. Electricians: The electricians perform much work in resident areas making repairs to over bed and ceiling lighting systems and many miscellaneous fixtures, which include but are not limited to the nursing call systems located at the beds, toilet areas, and bathtubs. Some repairs are performed at the wall receptacles near the floor, while miscellaneous repairs and servicing of equipment are performed in the laboratories, clinics, ~~surgery suite~~, radiology, central supply, kitchen, butcher shop and in the infectious waste room and hallways.

~~Precautions: As a general practice for all crafts persons, regular hand hygiene washing must be done both before and after working in patient care areas as well as subsequent to contact with articles which may be soiled with body substances.~~

5. Painters: The painters perform maintenance and repairs in all resident areas. While painters tend to perform only minor repairs in resident areas, painters move from resident area to area and therefore must observe the highest standards of care for the resident.

~~Precautions: As a general practice for all crafts persons, regular hand hygienewashing must be done both before and after working in resident care~~

~~areas as well as subsequent to contact with articles which may be soiled with body substances.~~

6. Carpenters: The carpenters perform numerous repairs and maintenance of many different types in all resident areas. These include but are not limited to wall, accessories used for and by residents, as well as doors, windows, bathrooms, toilet rooms, and flooring materials. Additionally, carpenters move from area to area and therefore must observe the highest standards of care for the resident.

~~Precautions: As a general practice for all crafts persons, regular hand hygiene washing must be done before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.~~

7. Stationary Engineers: The stationary engineers perform maintenance and repairs to a variety of equipment throughout the hospital, including but not limited to electric beds, wheelchairs, patient lifts, weighting scales, clothes washers and dryers. Additionally, maintenance and repairs are performed on kitchen and refrigeration storage equipment, compressing, weighting, drying equipment, some of which maintenance occurs either both clean and soiled linen sorting areas. Additionally, stationary engineers move from resident area to area and therefore must ———observe the highest standards of care for the resident.

8. Institutional Utility Workers: ~~The institutional utility worker performs work in all resident areas making repairs to bedside and ceiling lighting systems and many miscellaneous fixtures, which include but are not limited to the resident televisions, remote controls, and clocks. The utility worker~~The wheelchair engineer performs maintenance ~~and repairs and repairs~~ on wheelchairs both in the —ward areas and in the repair shop. Although an effort is made to repair the chairs when unoccupied by patients, the mechanical and electrical repair work could bring the engineer into contact with the resident's body fluids.

Standard Precautions: As a general practice for all tradespersons, regular hand hygiene washing must be done both before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

SUMMARY: All tradespersons are advised that hand hygiene washing before and after working in each area can have a significant positive effect on reduction of infection throughout the hospital.



Tradespersons are among the most mobile of workers in the hospital, moving freely among the wards; therefore, the simple but highly effective hand hygienewashing procedure is particularly important, regardless of the area in which the tradesperson is working.

EFFECTIVE DATE: 5/18/97

REFERENCES:

LHHPP 72-01 Infection Control Manual, C2 Standard Precautions  
LHHPP 72-01 Infection Control Manual, C4 Hand Hygiene

## GROUNDS POLICY

**SUBJECT:** Maintenance of the Hospital Grounds

**POLICY:** The grounds shall be maintained to provide safe access to and a safe environment for patients, employees, and visitors.

**PURPOSE:** To assure a safe environment and access to the grounds for patients, employees, and visitors.

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### PROCEDURE:

During all phases of construction or alterations of the grounds, a safe environment and access will be maintained for all who use the hospital.

All new construction will provide a safe and convenient use of grounds by patients as well as other health-limited or ~~handicapped disabled~~ individuals, and will meet criteria of regulatory bodies.

The hospital shall maintain and keep in safe condition all parking lots, roads, sidewalks, stairs, outside activity areas and landscape areas.

Sprinkler systems, benches, signs, and outdoor lighting shall be inspected and kept in good working order.

The Director of Facility Services or ~~the Maintenance Supervisor~~ designee shall inspect the hospital grounds monthly and ensure timely elimination of any reported Safety Hazards.

All parking should be in compliance with ADA requirements.

EFFECTIVE DATE: 5-14-97

~~BUILDING STANDARDS~~ CONSTRUCTION/RENOVATION STANDARDS

~~SUBJECT: Code Compliance with Building Standards~~

~~SUPERCEDES: LS-6 Building Standards~~ New

**POLICY:** The hospital shall be maintained to provide for physical safety of patients, employees, and visitors. The implementation of Interim Life Safety Measures will occur during construction/renovation and maintenance activities.

**PURPOSE:** To assure a safe environment for patients, employees, and visitors.

**PROCEDURE:**

The hospital shall be in compliance with the 1988 Life Safety Code of the National Fire Protection Association for existing buildings, as well as applicable federal state, local codes, and ADA requirements during construction, renovation or maintenance.

When the requirements are not met, a plan of correction shall be developed and the hospital shall initiate and document interim Life Safety Measures (ILSM) equivalent to the requirements.

~~Life safety levels shall not be diminished in any occupied area during any construction phase. The following guidelines should be observed:~~

~~Interim Life Safety Measures shall consist of the following actions:~~

~~Notify the Director of Nursing prior to construction of remodeling projects.~~

1. Prior to and during the remodeling and construction phases when dust is generated by demolition, ceiling and wall removals, sanding etc., dust partitions must be provided and maintained to prevent dust transfer from the construction site to other parts of the hospital.
2. Solid dust partitions should be from floor to ceiling, with taped joint.
3. Return air grills or ducts must be sealed to prevent contamination of ductwork.
4. All exits should be kept unobstructed or alternate routes are provided and/or posted. Personnel shall receive training if alternative exits must be designated. Buildings or areas under construction must maintain escape facilities for construction workers at all times. Means of egress in construction areas must be inspected daily by Facility Services.
5. Contractor to ensure that fire alarm, detection and suppression systems are not impaired. A temporary, but equivalent, shall be provided when any fire system is impaired. This may include the establishment of a fire watch.

- ~~3. Facility Services or the contractor will provide additional fire-fighting equipment and training on use for personnel.~~
- ~~6.~~
4. Construction area should be kept free of debris on a daily basis. Debris should be properly contained, transported and disposed. Dust at the debris box to be kept at a minimum.
- ~~5-7.~~ All exits should be kept unobstructed or alternate routes are provided and/or posted.
- ~~8.~~ A minimum of two fire drills per shift per quarter will be conducted in areas under ILSM.
- ~~6-9.~~ Areas should be kept fire safe (i.e., supply fire extinguisher to be on job site). The contractor is to provide a fire watch to be posted during welding and capping, etc. All construction personnel shall be trained in the use of fire alarms and extinguishers. Increased hazard surveillance of building, grounds, and equipment with special attention to evacuations, and construction storage will be conducted by Facility Services.
- ~~7.~~ Contractor to ensure that fire alarm, detection and suppression systems are not impaired. A temporary, but equivalent, system shall be provided when any fire safety system is impaired. A temporary, but equivalent, shall be provided when any fire system is impaired. This may include the establishment of a fire watch.
- ~~8-10.~~ Proper protective clothing and equipment's to be provided by the contractor. Facility Services will train personnel when structural or compartmentalization features of fire safety are compromised.
- ~~11.~~ Earthquake consideration should be given when storing materials and equipment. Facility Services will conduct facility-wide safety education programs to ensure awareness of Life Safety Code deficiencies, construction hazards and specific ILSM.
- ~~9-12.~~ Earthquake Consideration should be given when storing materials and equipment.
- ~~10-13.~~ All utility/system shut downs must be scheduled in advance with Engineering.
- ~~14-14.~~ Asbestos/lead removal shall be done by licensed contractor(s) only, required permits are to be posted at job sites.
- ~~12-15.~~ Fire stopping/sealing to be applied to all penetrations resulting from construction, cable pulling, remodeling at ceilings, one and two hour partitions, smoke partitions and floors.
- ~~13.~~ The Safety Engineer shall conduct a minimum of two fire drills per shift per quarter.
16. Smoking is prohibited in the hospital and hospital grounds except in designated smoking areas. The Director of Facility Services and/or State designated designee inspector(s) shall conduct daily construction/remodeling site to ensure compliance with this policy.

**PROCEDURES:**

1. The Facility Services department will implement and coordinate with the Safety Engineer the **ILSM**.
2. Once determined or implemented, the actions are to be documented by Facility Services, monitored by the Safety Engineer and forwarded to the Safety Committee for review and discussion.
3. Each project will be evaluated utilizing **ILSM-1** form to determine if ILSMs are required.
4. ILSMs required for each project will be identified by the Director of Facility Services in consultation with the Safety Engineer using the **ILSM-2** form.
5. The Construction Job Foreman using the **ILSM-3** form (Daily inspection checklist) will conduct daily inspections. This form will be distributed to the Director of Facility Services and a copy will be kept in the project file.

Attachments:

ILSM-1

ILSM-2

ILSM-3

**REFERENCES: LHH PP 72-01 Infection Control Manual, F1 Construction/Renovation**

EFFECTIVE DATE: 5-14-97

**LS-6**

**INTERIM LIFE SAFETY MEASURES (ILSM) LHH Pre-construction evaluation**

(Filled by Facility Services and Project Manager)

Project Manager: \_\_\_\_\_ Project Number: \_\_\_\_\_

Department/location of project: \_\_\_\_\_ Evaluator: \_\_\_\_\_

\_\_\_\_\_ Project description: \_\_\_\_\_

	<u>YES*</u>	<u>NO</u>	<u>N/A</u>
<u>1- Exit pathways will be altered obstructed or temporarily modified during the project.</u>			
<u>2- Fire protection devices including sprinklers, pull boxes, alarm, etc... will be modified, moved or altered during the project.</u>			
<u>3- Smoke and heat detectors will be disconnected covered or disabled during the project.</u>			
<u>4- Fire exit signs will be modified. Temporary signs and direction signs will be posted.</u>			
<u>5- Temporary partitions will be altered.</u>			
<u>6- Exterior exit pathways will be altered.</u>			
<u>7- Lighting in exit pathways, interior and exterior will be temporarily disabled.</u>			
<u>8- Walking surface will be temporarily altered.</u>			
<u>9- Access to emergency services, fire or police will be obstructed, changed or modified.</u>			

- 
- If YES, ILSMs are required. Indicate ILSMs on ILSM-2

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form Distribution: Facility Services, Safety Engineer, Project Manager

**FORM ILSM-1**

**INTERIM LIFE SAFETY MEASURES (ILSM) LHH**

**Requirement for construction projects**

(Filled by Plant Services and Project Manager)

Project Manager: \_\_\_\_\_ Project Number: \_\_\_\_\_

Department/location of project: \_\_\_\_\_ Evaluator: \_\_\_\_\_

\_\_\_\_\_ — Project description: \_\_\_\_\_

<b><u>CHECK APPLICABLE REQUIREMENT</u></b>	<b><u>REQUIREMENT</u></b>	<b><u>DATE COMPLETED</u></b>
	<u>Conduct supplementary fire drills according to a specific schedule, (conduct two fire drills per shift, per quarter, minimum). Specify frequency</u>	
	<u>Notify affected department Managers</u>	
	<u>Conduct organization wide education to promote awareness of LSC, deficiencies, construction hazards and ILSMs.</u>	
	<u>Post fire watch during work and reinstall detectors and monitoring devices at end of work period.</u>	
	<u>Post fire watch after regular work hours.</u>	
	<u>Install temporary automatic fire protection systems-Specifically:</u>	
	<u>Install smoke-tight partitions of non-combustible or limited combustible material.</u>	
	<u>Provide additional firefighting equipment-Specifically: Contractors to provide Fire Extinguisher on job site</u>	
	<u>Inspect and test temporary fire system monthly.</u>	
	<u>Post temporary exit and directional signs.</u>	
	<u>Remove debris daily.</u>	

CHECK APPLICABLE REQUIREMENT	REQUIREMENT	D COM
	Special access for the disabled is required.	Notify Emergency
	Other ILSM Measures: Enforce smoking	

services; Fire Department or Sheriff Department of changes in access Signature:

Date: \_\_\_\_\_

**FORM ILSM-2**

**INTERIM LIFE SAFETY MEASURES (ILSM)**

**Daily hazard Surveillance Checklist**

**Filled by Facility Services and /or Contractor**



Project Manager: \_\_\_\_\_ Project Number: \_\_\_\_\_  
 Department/location of project: \_\_\_\_\_ Evaluator: \_\_\_\_\_  
 Project description: \_\_\_\_\_

<u>Daily Evaluation Items (To be completed daily at end of work period)</u>	<u>N/A</u>	<u>YES</u>	<u>NO*</u>	<u>Other</u>
<u>1- Plant Services notified of detector and alarm system status.</u>				
<u>2- All debris has been removed from exit pathways and exit.</u>				
<u>3- Fire alarm systems are in working condition.</u>				
<u>4- Exit pathways are clear and unobstructed.</u>				
<u>5- Sprinkler systems are unobstructed and in working condition.</u>				
<u>6- Fire extinguishers are present and charged.</u>				
<u>7- Temporary signs are posted to indicate exit pathway.</u>				
<u>8- Automatic fire suppresser system are in working condition.</u>				
<u>9- All combustibles are stored properly.</u>				
<u>10- Housekeeping is neat and orderly.</u>				
<u>11- Partitions (if used) are smoke tight and non-combustible material.</u>				
<u>12- Inspections of the fire protection equipment are current.</u>				
<u>13- Systems, (phone, radio) are provided to summon help in an emergency.</u>				
<u>14- Prohibit smoking enforced.</u>				

\*If "no" is answered, ILSM may need to be implemented or modified

Explain other: \_\_\_\_\_

\_\_\_\_\_  
 Safety Engineer Date:

**FORM ILSM-3**

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## TRANSCRIPTION SERVICES

### PROCESSING EQA REPORTS:

#### POLICY:

Process, research and correct incomplete transcribed reports that were dictated by LHH Clinicians, and are listed on the EQA Report from the outside Transcription Company.

#### PURPOSE:

To ~~ensure~~<sup>enhance</sup> the quality of transcribed documentation by ~~materials~~ researching missing elements or seeking the correct documentation when there is a question regarding an error or questionable word or component of a report. ~~in the process~~

#### PROCEDURE:

1. **Transcribed reports are received from the outside Transcription vendor for the following reasons:**
  - a. No date of service provided for the report when dictated.
  - b. Age discrepancy of more than a one year period of time.
  - c. A transcribed report that contains four or more blank areas.
  - d. Unknown patient: No identifying information or incorrect medical record number or incorrect account number.
  - e. Discrepancies within the body of the transcribed report: two different lab values, he vs. she, etc...
2. There may be routine calls from medical staff regarding an issues they may be experiencing when trying to access the dictation system, during dictation of a report or at the end of their dictating session.
3. There may be a request for immediate resolution from staff of dictation with the incorrect work-type, wrong dates, etc.

Revised:

Original adoption: 2015/08

## ADMINISTRATION

### SCOPE OF SERVICE:

### POLICY:

- Policy & Procedures will be developed and maintained for Health Information Services. These Policies & Procedures will be updated annually.

### PURPOSE:

- The primary purpose of the policies and procedures that govern Health Information Services (HIS) is to establish a uniform set of guidelines in the implementation and maintenance of patient/resident information in relation to the residents/patients protected health information.

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### I. APPLICABILITY:

- ~~A.~~ LHH medical records shall be maintained uniformly for all patients without regard to race, color, creed, national origin, age, sex, religion or handicapdisabilitiy.

### II. RESPONSIBILITY:

- A. ~~HIS Health Information Services is~~ Health Information Services is under the direct supervision of a credentialed Health Information Director.
- B. The Director is responsible for the maintenance, preservation and completion of all medical records as indicated as well as the confidentiality of such information.
- ~~C. The daily supervision of Health Information Services is the responsibility of the Assistant Director.~~

Most recent review: 08/2008, 08/2009, 06/2015  
Revised: 08/10/2009, 06/22/2015  
Original adoption: 08/1986

## ADMINISTRATION

### CHANGE OF OWNERSHIP/CESSATION OF LAGUNA HONDA HOSPITAL:

#### POLICY:

Laguna Honda Hospital will arrange for the safe preservation, custodianship and location of all medical records in the event of change of ownership or cessation of operation; and will notify the Department of Health Services whenever medical records are defaced or destroyed during the retention period.

#### PURPOSE:

To provide documentation that assures continuity of patient care, and satisfies legal requirements.

#### PROCEDURE:

1. The Director of Health Information Services arranges for the safe preservation of patients medical records if the facility ceases operation; and reports these arrangements in writing to the Administrator. ~~The Administrator.~~ The Administrator will provide written notification of the arrangements to the Department of Health Services within three (3) business days.
2. The Administrator provides the Department of Health Services written documentation, if the facility changes ownership. This documentation will be sent prior to the change of ownership and states:
  - a. That the new licensee will have custody of patient medical records and these will be available to the former and new licensees, and other authorized persons; or
  - b. The reasons for the unavailability of such records.
3. The Director of Health Information Services informs the Administrator in writing, whenever the patient medical records are defaced or destroyed during the retention period. The Executive Administrator will provide the Department of Health Services with written documentation of such occurrences within three (3) business days.

Most recent review: ~~08/2008, 08/2009, 06/2015~~

Revised: ~~2009/08/10/2009~~

Original adoption: ~~1986/08/4986~~

## HUMAN RESOURCES

### VACATION REQUESTS

#### PURPOSE:

~~Proper~~ Scheduling of vacations is ~~needed~~ required to ensure adequate staffing to meet the operational needs of the ~~service department as well as the hospital~~ and to provide a fair and equitable means for employees to request and be granted vacation

#### PROCEDURE:

##### ~~1.~~ VACATION

###### 1.

After completing one year of employment, and through the fourth year, an employee is entitled to .0385 of an hour times total paid hours for a maximum of 10 days per year.

###### a.

~~A.~~ After five (5) and until fifteen (15) years of service, an employee is entitled to .0577 of an hour times total paid hours for a maximum of 15 days per calendar year.

###### b.

~~B.~~ After fifteen (15) years of continuous service, an employee is entitled to .0770 times total paid hours for a maximum of 20 days per year.

###### c.

#### ACCUMULATION OF VACATION

##### 2.

a. ~~A.~~ The balance of one's vacation allowance may be accumulated according to the following schedule.

<u>Years of City Employment</u>	<u>12-Month Award Maximum</u>	<u>Maximum Balance</u>
<u>1 to 5 years</u>	<u>80 hours</u>	<u>320 hours</u>
<u>5 to 15 years</u>	<u>120 hours</u>	<u>360 hours</u>
<u>15 years and over</u>	<u>160 hours</u>	<u>400 hours</u>

<u>Years of City Employment</u>	<u>12-Month Award Maximum</u>	<u>Maximum Balance</u>
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<u>5 to 15 years</u>	<u>120 hours</u>	<u>360 hours</u>
<u>15 years and over</u>	<u>160 hours</u>	<u>400 hours</u>

~~a.b.~~ Vacation allowance may be used on an intermittent daily basis with prior approval by management.

~~Years of City  
Employment  
1 to 5 years  
5 to 15 years  
15 years and over 160 hours- 400 hours~~

~~B. Vacation allowance may be used on an intermittent daily basis with supervisory approval by management.~~

~~Most recent review: 08/2008, 08/2009, 07/2015~~

~~Revised: 2009/08/10/2009, 2015/07/13/2015~~

~~Original adoption: 1986/08/1986~~

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<u>5 to 15 years</u>	<u>120 hours</u>	<u>360 hours</u>
<u>15 years and over</u>	<u>160 hours</u>	<u>400 hours</u>

## HUMAN RESOURCES

### PERFORMANCE EVALUATIONS:

#### POLICY:

Every employee will have their performance evaluated according to hospital policy.

#### PURPOSE:

- ~~To monitor performance~~ provide every employee with clear written performance expectations and feedback about their performance.

#### PROCEDURE:

##### I. PERFORMANCE EVALUATION

1.

~~A.~~ The Civil Service Commission has implemented an Employee Performance Evaluation procedure, and it applies to all employees.

a.

~~a.~~ Periodic evaluation ~~conferences-meetings~~ meetings will be held by ~~the supervisor~~ management with the employee. The first ~~conference-meeting will occur~~ meeting will occur at the time of initial employment, where a discussion of what the goals, expectations, standards, skills and knowledge, -will be discussed. ~~A the report's~~ written statement of employee's duties, key learnings are documented. ~~At s~~ subsequent conferences-meetings, management and the employee will monitor the employee's progress, identify any additional training needs, review achievements and provide any necessary assistance.

b. ~~The reports are completed in duplicate and signed by the employee and the supervisor~~

~~B.~~ The reports are completed in duplicate and signed by the employee and the management. They are forwarded to the next level supervisor for comment or any necessary action. The original is then sent to the ~~Personnel~~ Human



Resources Office and a copy is ~~forwarded~~ provided to the employee. The information in the report is completely confidential.

c.  
~~b-d.~~ Performance reports are due as follows:

Permanent employees:	Annually
Temporary Civil Service:	Annually
Limited Tenure:	Annually
Non-Civil Service:	After 90 days on the job
Probationary	
6 months probation:	End of third month End of fifth month
1 year probation:	End of third month End of sixth month End of eleventh month
Separated from service or transferred:	month 7 days prior to leaving

~~Most recent review: 08/2008,  
08/2009, 07/2015~~

Revised: ~~2009/08/10,~~

~~2015/07/13/2015~~

Original adoption: ~~1986/08/1986~~

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## HUMAN RESOURCES

### INSERVICE CONTINUED EDUCATION AND TRAINING:

#### **POLICY:**

~~A systematic program of orientation, o~~On-the-job training, specialized training and regular in-service training shall be ~~developed and implemented for~~ available for all Health Information Services employees.

#### **PURPOSE:**

1. Reduce potential liability ~~because of~~ due to error(s).
2. Create a positive motivational environment.
3. Enhance employee productivity and efficiency.
4. Enhance employee opportunity for promotion.

~~5.4.~~

#### **PROCEDURE:**

1. Participation in in-service programs that reflect critical issues, such as (fire drills and safety practices) shall be mandatory.
2. Participation in the in-service programs required by Title XXII shall ~~also be~~ mandatory.
3. Employee(s) shall have the option of choosing the available in-service times.
4. Documentation of attendance shall be kept ~~by the technical supervisor of~~ for each employee.
5. Documentation of attendance shall be kept along with a copy of any C.E. certificate by the management and the employee.
- ~~5.6.~~ Management ~~and supervising staff~~ shall participate regularly in professional association meetings, conferences and workshops as approved ~~by the director~~.
- ~~6.7.~~ Appropriate budgetary support of these activities shall be made available when possible.
- ~~7.8.~~ ~~Documentation of attendance shall be kept along with a copy of any C.E. certificate by the technical supervisor.~~
- 8.9. Each ~~Accredited Registered Health Information Records~~ Technologist (RHIT), Certified Coding Specialist (CCS), Certified Coding Associate (CCA), etc... shall ~~provide~~ provide a copy of their AHIMA ~~approach CE cycle~~ form, when received and completed before the end of their CE cycle, to management ~~the technical supervisor~~.

Most recent review: ~~08/2008, 08/2009, 07/2015~~

Revised: ~~2009/08/10/2009, 2015/07/13/2015~~

Original adoption: ~~1986/08/1986~~

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## CONTENT AND SEQUENCE OF THE MEDICAL RECORD FORMS

### FORMS

#### POLICY:

~~4-~~ Only forms approved by the Medical Record Committee will be authorized for use in the patient/resident's medical record.

#### PURPOSE:

~~4-~~ Standardized forms shall be developed in order to achieve the following:

- 1) Foster ease of access to information;
- 2) ~~Routinize~~ Facilitate the placement of protected health information within the medical record;
- 3) Reduce the possibility of error by the practitioner when adding to data and accessing and using information;
- 4) Foster ease of distribution of information;
- 5) Provide for uniform entry of patient/resident identification, assessment and treatment.

The ~~Medical Record Committee is the~~ Forms Committee is a component of the Medical Record Committee and has the responsibility to review, make recommendations and either deny or approve of all new forms, periodically review existing forms, and recommend the deletion of old forms.

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#### PROCEDURE:

##### 1. ~~I-Approval Process~~ PROVAL PROCESS

- a. The Department that owns the form (new or revision) will ~~notifies request to be placed on the next MRC Agenda by HIS. Regarding form (new or revised).~~
- b. ~~Form presentation is put on MRC agenda.~~ The HIS department will provide a Request form to modify a form or create a new form to the requester.
- c. The Department that owns the form will send a designated Person ~~either to the MRC meeting to present the form~~ and respond to any questions

pertaining to the form. ~~\_\_presents form to committee or gives to members who are present.~~

~~d.~~ After the draft of the form has been created, reviewed, and presented to the MRC, ~~request for use of~~ the form is either denied, given temporary approval or final approval. ~~For temporary approval given—the form discussed at later date.~~ E) Director of HIS issues forms number.

~~d.~~

~~a.~~ ~~Format is standardized.~~

~~e.~~

~~e.f.~~ Form sent to the forms vendor who proceeds with typesetting and printing.

The ~~Director of HIS~~ shall maintain a forms control book and inventory numbers are given to the Materials Manager

~~Inventory is monitored monthly and~~ forms are reordered or revised as needed.

Most recent review: ~~08/2008, 08/2009, 6/2015~~

Revised: ~~2009/08/10/2009, 2015/06/2015~~

Original adoption: ~~1986/08/1986~~

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## CONTENT AND SEQUENCE OF THE MEDICAL RECORD

### ADMISSION DIAGNOSIS:

**POLICY:** ~~Upon admission~~

~~All, at~~ appropriate diagnoses will be captured and coded for each patient/resident following admission.

### PURPOSE:

~~To provide the~~ capture the initial coded diagnosis ~~in order to begin providing service, and for reimbursement. that support services being provided and for reimbursement.~~

### PROCEDURE:

When you receive a notification that a patient has been admitted or readmitted to your assigned ward, you will need to code all the admission diagnoses from the physician's orders and enter the codes into ~~the Patient Information System~~ the Nuance Quantim. Use the following steps to complete the procedure:

- ~~1. Type your user ID and password, then press ENTER. password, click sign in button. As you enter your user ID and password, it will automatically wrap around as you type in your password. Your password will not appear on the password line, so don't worry about it.~~
- ~~2. TAB over to the Applications section. MOVE the cursor down to the highlight the Patient Information Systems (MR), and press ENTER. Click coding abstracting tab.~~
- ~~3. Press PF1 MEDICAL RECORD PROCESSING.~~
- ~~4. Press PF1 Medical History File Maint.~~
- ~~5. Press ENTER to continue.~~
- ~~6-1.~~ To locate the current admission ~~you need to enter your diagnosis codes,~~ you have the following options:
  - ~~a.~~ **PATIENT NAME:** Type only the Patient's Last Full Name. This option will display all the patient's last names encounters. ~~In order to find the admission you need, press PF5, to display the next 8 patients. MOVE the cursor, down or up, to select the admission that you need to update, Or~~
  - ~~b-a.~~ **MEDICAL RECORD #:** Type the Medical record number without any dashes. ~~Be sure to include the 7th digit.~~ This option will display all the patient's admissions. MOVE the cursor, down or up, to select the admission that that you need to update, Or
  - ~~e-b.~~ **PATIENT # (Account #):** Type the Patient account Number, if you know it. This option takes you directly to the admission that you will use to update your admission diagnosis.

~~Press ENTER. You are now in the I/P Medical Records Update Screen. This displays the patient's name, ward, DOB, admission and discharge date.~~

- ~~7. Place the cursor next to the admission where you need to update your diagnosis code. If you did not see the current admission on the screen, press PF5 to display the next 8 patients.~~
- ~~8. Press ENTER.~~
- ~~9. You are now in the I/P Medical Records Update Screen to enter the ICD-9-CM codes. Use the TAB or the cursor keys to get the next line.~~
- ~~10. Press PF5 to verify the diagnosis codes after you have entered them into the computer.~~
- ~~11. Press PF8 to print the screen.~~
- ~~12. To exit completely out of PIS, simply press PF16 three times.~~
- ~~13. To make the diagnosis conform with the physician, write in the diagnosis in the Modifiers section. See attachment A.~~
- ~~14. Write in the Ward and title "Admission-Diagnosis" at the top right side of the printout.~~
- ~~15. Make 5 copies of the printout. Keep one for your files. Submit the other 4 copies to the Admission Diagnosis Coordinator.~~
2. Click on Account # for the admission you need to code.
3. On the patient Info screen Type 30 into discharge status field and select status 33 in the coding status drop down menu.
4. Click code books tab.
5. Enter admission code in to code box (DA)
6. Enter all the diagnosis in to code box (DX)
7. Go to view encounters drop-down menu and select coding (P)
8. Type Y in POA box (If the condition is present at the time of admission)
9. Click Save
10. Click print icon and print three copies( One for your assigned coder, One for your Binder and One for your team lead)

~~Revised: 08/10/2009, 06/2015~~ \_\_\_\_\_ P. 1

~~Revised: 2009/08/10, 2015/06, 06/2015~~

Original adoption: 08/1986

## DISCHARGE PROCESS

### ABSTRACT PROCEDURE:

#### POLICY:

————All records of discharged patients shall be abstracted.

#### PURPOSE:

————To document for statistical purposes care rendered.

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#### PROCEDURE:

1. Log into [The Nuance Quantim system](#)
2. Enter [\[MRN, acct# or last name\]](#) of the patient's discharge chart to begin coding.
3. Select the encounter [associated with the discharge date](#)

#### Screen #1

Patient Information Screen – Items [listed below will be to completed](#)

- I. Admit date and Admit Time are completed
- II. Discharge Date and Time
- III. Discharge Status
- IV. Attending Provider
- V. Coder
- VI. Coding Status

**Coder Box** - Click on [the arrow to view the dropdown menu](#), [\[select your name as coder\]](#).

1. Admit Date/Time: Information is [interfaced into the Quantim system downloaded upon admission](#)
2. Discharge Date/Time: Enter [\[discharge date\]](#) ~~this information~~ from discharge analysis deficiency slip
3. Discharge Status: Click on the icon to open the discharge disposition lookup menu and select [\[discharge disposition\]](#).



4. Attending Provider: This is usually completed but sometimes it's wrong. Click on the icon to open the attending provider lookup menu and [select the correct provider] if the provider name is incorrect.

**Coding Status:** Click on the arrow to see the drop pull down menu and select [COMPLETE].

Click on the View Encounter arrow to view drop pull down menu. Choose [LHH IP DEMOGRAPHICS].

Choose LHH IP Demographics.

## **SCREEN #2**

**LHH IP Demographics – The Items listed below will be completed in this section:**

- I. Readmission Indicator
- II. Admitting MD
- III. Do Not Resuscitate
- IV. Restraints
- V. Referring MD
- VI. Admission Source
- VII. Unit
- VIII. Advance Directive
- IX. Referring Facility
- X. Transfer To
- XI. Ethnicity
- XII. Race
- XIII. Zip Code

1. Readmission Indicator: Click on the arrow to view the pull drop down menu.
  - a. Select "[YES]" if the resident has previous LHH admissions
  - b. Select "[NO]" if this is the residents 1<sup>st</sup> admission to LHH.
2. Admitting MD: This is usually completed but sometimes it's wrong. Click on the icon to open the Admitting MD lookup menu and [select the correct provider].
3. Do Not Resuscitate: If residents advance Directive is DNR - Select "[Yes]"
  - a. If resident is Full Code, then select "[NO]"

4. **Restraints:** Click on the arrow to open the ~~pull~~ drop down menu. If the resident has a restraint documentation in the record, there should be a consent form for the use of restraints which is required as a selection of ~~-.~~ Select "[YES]".
5. **Referring MD:** Enter [name (last, first) or MD] that ordered the restraint.
  - a. If NO or UNKNOWN, enter [NO] or [UNKNOWN]
6. **Admission Source:** Click on the arrow to open the ~~pull~~ drop down menu.
  - a. Where did the resident come from HOME, PRISON/JAIL, RESIDENTIAL CARE FACILITY (BOARD & CARE), ACUTE HOSPITAL (PM ACUTE MEDICAL, SFGH, UCSF, ETC.), ACUTE REHAB FACILITY (PM ACUTE REHAB), and SNF/IFC (OUR SNF OR OUTSIDE SNF). Click on correct admission source.
7. **Unit:** Click on the arrow to open the ~~pull~~ drop down menu and select the unit that the resident was discharged from.
8. **Advance Directive:** Click on the arrow to open ~~pull~~ drop down menu.
  - a. Does the resident have an Advance Directive? This should always be [yes].
9. **Referring Facility:** Click on the arrow to open the ~~pull~~ drop down menu.
  - a. This is the second part needed to identify the admission source. Select [the facility name] the resident came from.
10. **Transfer To:** Click on the arrow to open the ~~pull~~ drop down menu.
  - a. Where was the resident discharged to? [Select the facility name] that the resident was discharged to.
11. **Ethnicity:** Click on the arrow to open the ~~pull~~ drop down menu.
  - a. Select [the ethnicity type] according to documentation in the record.
12. **Race:** Click on the arrow to open the ~~pull~~ drop down menu.
  - a. Select [the Race] ~~type~~ according to documentation in the record.

- 13. Zip Code:** Click on the arrow to open the ~~drop-pu~~ down menu.
- a. **Outside admissions:** Enter [the zip code] for the patient's address.
  - b. **In-house admissions:** Enter [LHH zip code: 94116]  
(Our SNF to Our ACUTE and Our ACUTE to Our SNF)

Click on the [View Encounter] arrow to view the ~~drop-pu~~ down menu.

Choose [IP OSHPD]

### **SCREEN #8**

**LHH IP OSHPD – Items to be completed:**

- I. OSHPD Licensure of Site
- II. Route

- 1. **OSHPD licensure of Site:** Click on arrow to open pull down menu.
  - a. Select [1], THIS HOSPITAL, if resident was admitted from LHH
  - b. Select [2], ANOTHER HOSPITAL, if resident was admitted from ANOTHER HOSPITAL.
  - c. Select [3], NOT A HOSPITAL, if resident came from HOME, B&C.
  
- 2. **Route:** Click on the arrow to open the ~~drop-pu~~ down menu.
  - a. Select [1], E.D. THIS HOSPITAL, if resident was admitted from the HOSPITAL EMERGENCY DEPARTMENT.
  - b. Select [2], NO E.D. VISIT, if resident was NOT admitted from THE HOSPITAL EMERGENCY DEPARTMENT.

Click on the View Encounter arrow to view the ~~drop-pu~~ down menu. Select [Coding].

Choose CODING

### **SCREEN #3**

**LHH CODING – Items to be completed in this section:-**

- I. Discharge Codes
- II. POA ( Diagnosis PRESENT ON ADMISSION)

1. **Discharge Codes:** Enter [diagnoses codes] upon review of the resident's medical record.
2. **POA:**
  - a. Enter [Y] (yes) if diagnosis was PRESENT ON ADMISSION
  - b. Enter [N] (no) if diagnosis was NOT PRESENT ON ADMISSION (this would be used for NEW DIAGNOSIS that occurred while resident is in house and are STILL PRESENT at discharge, and the DIAGNOSIS that triggered the discharge.
  - c. Enter [1] (number one) if the diagnosis is EXEMPT from reporting to OSHPD (This list is updated annually)

Click on the View Encounter arrow to view the dropdown menu. Select [LHH CONCURRENT DIAGNOSES]

Choose LHH CONCURRENT DIAGNOSES

### **SCREEN #10**

**LHH CONCURRENT DIAGNOSES** – Items to be completed in this section:

- I. Onset Date
- II. Abstracting Status

1. **Onset Date:**
  - a. Enter [ADMIT DATE], if diagnoses was PRESENT ON ADMISSION.
  - b. Enter [DISCHARGE DATE], if diagnoses is the REASON FOR DISCHARGE
  - c. Enter [ONSET DATE], if diagnoses occurred while IN HOUSE and are STILL PRESENT at discharge.

2. **Abstracting Status:** Click on the arrow to open the dropdown menu.
  - a. Choose-Select [COMPLETE]

Select the [SAVE]! Button.

**POP UP WINDOWS:** Popup windows will show both Errors and Warnings.

- a. Clicking on [save] generates this pop up window.

- b. Errors and Warnings are highlighted in Yellow and/or Red
- c. **Yellow highlights:** System will allow you to save with Yellow highlights.  
Review the errors and warnings and make corrections if applicable.  
If it does not apply, then don't change.
- d. **Red highlights:** System will NOT allow you to save with RED highlights.  
Review the errors and warnings and make corrections. All corrections listed must be corrected before you can save.

### E-codes: E-codes are used for incidents that occur at LHH only

- a. **Codes that are required are as follows:**
  - a. E-code describing the incident i.e Falls
    - 1. E884.4 –fall from bed
  - b. E-code describing the place of occurrence i.e LHH
    - 1. E849.7 – Accident occurred in a residential institution
  - c. E-code describing External cause of incident.
  - d. E-code describing the Activity when incident occurred.
    - 1. C and D are new codes and will show in the pop up window whenever you assign an E-code. Read the descriptions and assign code.

### E-codes continued:-

Print Coding Summary: Click on the arrow the open the ~~drop~~ down menu.

Print Abstracting Summary: Click on the arrow the open the ~~drop~~ down menu.

Once the Abstracting Summary is printed, ~~select~~ [-save] again and you are done!

**BEDHOLDS:** Bed holds occur when ~~our~~ LHH residents are discharged to our acute medical or acute care at another hospital (SFGH, UCSF etc.).

If a resident has been discharged to our Acute Medical or to Another Acute Care facility, ~~the~~ diagnoses must be entered in the bed hold account.

1. Log into the **INVISION SYSTEM**.

PLEASE ENTER USER ID:

PASSWORD:

2. Enter [01] – Patient Inquiry (EAD), enter

3. Enter [ID Type Code]: MR (Medical Record Number)

4. Enter [Enrollee ID: MRN (xxxxxxx)], enter

5. Verify Patient Screen, enter

6. Patient Menu Screen, “ABSTRACTING OPTIONS”

Enter [11 (IP Diagnosis & Procedures)], enter

7. Select behold account number from the case list, enter

8. Enter [01]. enter

9. Enter [Diagnosis] as listed on your coding summary form, enter

10. Print copy of INVISION SCREEN with diagnoses and attach to Coding Summary form from Quantim.

11. BLOOD TRANSFUSIONS:

a. Enter [date] when transfusion was done.

b. Enter [the physician's identification number].

c. Enter the [number of units of blood] transfused.

d. Refer to the Blood Transfusion Record in the patient's chart for this information.

~~**A) ITEM 1 - HOSPITAL CODE:**~~

~~I) Enter 10 – Acute (M-7) discharges II) 20 – SNF discharges~~

~~III) 30 – Acute (L-4A) discharges~~

~~**B) ITEM 2 - MEDICAL RECORD NUMBER:**~~

~~I) Check if patient's 7 digit hospital medical record number is correct.~~

~~II) Enter the initials of the person completing the abstract.~~

~~**C) ITEM 3 - PATIENT BILLING #:**~~

~~I) This will show the patient's billing number.~~

~~**D) ITEM 4A - PATIENT LAST NAME:**~~

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~~I) Enter the patient's last name~~

~~**E) ITEM 4B - FIRST NAME:**~~

~~I) Enter the patient's first name and middle initial if any.~~

~~**F) ITEM 5 - BIRTH DATE:**~~

~~I) Enter the patient's date of birth.~~

~~**G) ITEM 6 - ZIP CODE:**~~

~~I) Outside admissions enter the proper zip code for the patient's address.~~

~~II) Inhouse admissions enter 94116. III) Examples: M-7 to C-4~~

~~1. F-6 to M-7~~

~~2. M-5 to L-4A~~

~~3. L-4A to L4S~~

~~**H) ITEM 7 - SEX:**~~

~~I) F - female~~

~~II) M - male~~

~~**I) ITEM 8 - RACE:**~~

~~I) Enter race code. (See attachment.)~~

~~**J) ITEM 9 - RELIGION:**~~

~~I) Enter code for religion. (See attachment.)~~

~~**K) ITEM 10A - ADMIT DATE:**~~

~~I) Enter the patient's admission date.~~

~~**L) ITEM 10B - ADMIT TIME:**~~

~~I) Enter the time of admission.~~

~~**M) ITEM 11 - ADMIT DIAGNOSIS:**~~

~~I) This will show the admission diagnosis code entered previously. Check if the code is correct.~~

~~**N) ITEM 12 - ADMITTING PHYSICIAN:**~~

~~I) Enter the admitting physician's identification number.~~

~~**O) ITEM 13 - READMIT:**~~

~~I) Enter Y or N.~~

~~**P) ITEM 14 - PRIOR:**~~

~~I) Ignore.~~

~~Q) — ITEM 15 — ADMIT TYPE:~~

~~I) — Enter admit type code.~~

~~R) — ITEM 16 — ADMIT SOURCE:~~

~~I) — Enter source of admission code. This should identify where the patient was admitted from.~~

~~S) — ITEM 17 — PAY SOURCE:~~

~~I) — Enter the patient's financial class code.~~

~~T) — ITEM 18 — TOTAL CHARGES:~~

~~I) — Enter the amount of total charges rounded to the nearest dollar.~~

~~II) — Find the amount in the Monthly Patient Charge List binder.~~

~~U) — ITEM 19A — DISCHARGE DATE:~~

~~I) — Enter the patient's discharge date.~~

~~V) — ITEM 19B — DISCHARGE TIME:~~

~~I) — The time of discharge is already entered.~~

~~W) — ITEM 20 — DISCHARGE STATUS:~~

~~I) — Enter discharge status code. This should identify where the patient was discharged to.~~

~~X) — ITEM 21 — EXPIRED DESCRIPTION:~~

~~I) — Enter A if autopsy was performed. II) Enter C if coroner's case.~~

~~Y) — ITEMS 22 to 30 — DIAGNOSES~~

~~I) — Enter the ICD9-CM codes starting with the principal code. The codes should be entered in the proper sequence.~~

~~Z) — ITEMS 31 to 38 — PHYSICIANS:~~

~~I) — Enter the physician's identification numbers for the attending, referring and up to six consultants.~~

~~II) — ITEM 39 — BLOOD TRANSFUSIONS:~~

~~III) — Enter date when transfusion was done.~~

~~IV) — Enter the physician's identification number.~~

~~V) — Enter the number of units of blood transfused.~~

~~VI) — Refer to the Blood Transfusion Record in the patient's chart for this information.~~



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~~VII) ITEMS 40 to 44 - E-CODES: I) Enter E codes if any.~~

~~VIII) ITEMS 45 to 50 - SURGICAL/NONSURGICAL PROCEDURES:~~

~~IX) Enter the surgeon's identification number, date of procedure, code for anesthesia used and up to five procedures can be entered.~~

~~Most recent review: 08/2008, 08/2009, 07/2015~~

Revised: 2009/08/10/2009, 2015/07/2015

Original adoption: 1986/08/1986

## DISCHARGE PROCESSING

### COMPLETION OF MEDICAL RECORDS:

#### POLICY:

4. All medical records of discharged patients must be completed and filed within thirty (30) days after discharge date when discharged from a Skilled Nursing Facility (SNF) and within fourteen (14) days when discharged from an Acute facility.

#### PURPOSE:

4. To support continuity of care through the provision of complete and accurate health information for each patient/resident

#### PROCEDURE:

##### I. ~~INCOMPLETE INDEX~~ INCOMPLETE INDEX: DEFICIENCIES:

A. ~~An index card file is kept for logging of deficiencies of all analyzed incomplete charts. Logging of deficiencies of all analyzed incomplete records is done entered, tracked and processed using - the Medrec Millenium Chart Completion system, in the Chart deficiency module.~~

- ~~The index card file includes sections for~~ The chart deficiency module includes sections for logging of deficiencies as follows: The following information from the medical record is entered into the system: Name, Medical Record number, account number, volume number, admission and discharge date, type of deficiency, deficiency date and color tag and name of provider.

<u>Name</u>	<u>M.R.#</u>	<u>Unit#</u>	<u>D/C (Discharge Date)</u>	<u>Delinquent Date</u>	<u>Deficiency</u>	<u>Signed Progress Note</u>
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- ~~Delinquency Date is determined by calculating 30 days from the discharge date if resident discharged from a SNF Unit, and calculating 14 days from the discharge date if the patient is discharged from an Acute Unit. Consideration is given to a 5-day grace period if logging of deficiency is done close to Delinquent date from D/C (discharge) date due to the chart being received late in Health Information Services. —? Do you want to continue this?~~

Deficiencies may be identified by the medical record number or by the individual provider names.

#### Deficiency look up for individual providers:

- Log in to Chart Deficiency.
- Click on Provider
- Add Visit (Default Today's Date) if a provider completes the deficiencies.

## II. DEFICIENCY FORMS

- A. All incomplete ~~charts~~ medical records will have ~~a yellow deficiency forms~~ chart deficiency slip ~~used~~ that was printed by the analyst ~~from chart deficiency module,~~ after at the completion of the analysis process. ~~The to record deficiencies,~~ to record deficiencies to be completed, ~~may be any combination of the following~~ i.e., signatures missing, discharge summary to be dictated, initial error, etc.

~~When a new chart is turned forward in to the Physician Completion desk~~ incomplete desk, ~~the entire chart is briefly reviewed to confirm that there are deficiencies in the record~~ the whole chart before filing it to shelf.

~~When analyzing the record for completeness, validate that the Review History and Physical and Discharge~~ the Discharge Summary are either filed in chart or marked as deficiency in Chart deficiency module and on the chart deficiency slip.

~~Check the MPI to make sure all of the medical record volumes are attached to the correct episode (stay).~~

~~Make sure the medical records of expired residents/patients have an expired label~~ attached to the front of the medical record, if not, return the medical record back to the discharge analyst, so that the expired sticker may be attached to the outside of the medical record folder.

~~This form and chart is reviewed at the Incomplete Desk for accuracy and any errors should be corrected before logging of deficiencies on index cards.~~

- ~~4. Each chart is reviewed for missing documentation listed below even if it is not entered in the system. Each complete chart is also reviewed for missing papers regardless if it's not entered as missing on yellow deficiency form.~~

~~2.1. Documentation papers checked~~ that should be filed in the chart are:

- ~~a) Face sheet~~
- ~~b) Conditions of admissions~~
- ~~c) Chronological record if patient permanently discharged or expired~~
- ~~d) Discharge summary~~
- ~~e) History and physical~~
- ~~f) Care plan~~
- ~~g) Activity initial assessment and attendance records~~
- ~~h) Social services initial assessment and discharge plan~~
- ~~i) Inventory record~~

- ~~3. All missing papers, i.e., ADL's nursing notes, x-ray report, etc. should be listed on a white index card with patient's name, M.R. #, unit and D/C date and put in pocket on outside of chart. As each missing paper is filed in the chart, it should be crossed off the missing list.~~

4. ~~When the recording of all deficiencies have been completed, the original deficiency form (yellow) stays inside the front of the chart to be referred to and each deficiency is crossed off and dated when completed by each caregiver. The corresponding color tags are then removed from the form when completed.~~
5. ~~The white copy of the deficiency form is taken out of the chart and filed alphabetically in the black file box. This file is used as a manual cross-reference guide.~~
6. ~~After charts have been coded by the coders, the yellow deficiency forms are pulled out by the coders and returned to the Incomplete Desk.~~
7. ~~When the yellow deficiency forms are received, the white forms from the black file box are pulled and matched with the yellow forms and are then given to Louise.~~

#### Updating Deficiency in Chart deficiency after provider has completed the record:

- Click on Chart tab.
- Search for patient's encounter; select correct episode.
- Highlight the provider's name and deficiency that has been completed by provider and update the deficiencies by clicking on [complete].
- Click [Save] to update the deficiency system.

### III. LOOSE PAPER PHI ALPHABETIZED TERMINAL DIGIT FILING FOLDER

A. Process for loose PHI documents ~~Papers~~ received ~~of for~~ recently discharged patients, after the medical record(s) ~~charts~~ have already been received in Health Information Services.

1. ~~The Physician Completion Incomplete Desk accepts loose PHI documents paper filing on for patients whose charts- medical records that have been analyzed and are currently filed on the Physician Completion shelves. and updates the chart deficiency module.~~
2. ~~The Loose PHI documents papers that are accepted by at Physician Incompletion incomplete desk and are updated in the Chart Deficiency module are: the Discharge Summary, History and Physical and the Advance Directives. and are updated in chart deficiency module.~~
1. ~~but have not yet been logged on index cards.~~
2. ~~When logging of deficiencies on a newly analyzed chart, these papers are pulled from the loose paper filing folder and put into the chart. They are then crossed off the list of missing papers that they analyst has recorded.~~
3. ~~Loose papers that are accepted include:~~
  - a) ~~Social Services discharge plan and progress notes~~
  - b) ~~Activity Therapy initial assessment and attendance records~~
  - c) ~~Face sheet~~

- ~~e) Conditions of admissions~~
- ~~e) Chronological record~~
- ~~f) Care plan~~
- ~~g) Progress notes and ADLs~~
- ~~h) Inventory record~~
- ~~i) P.T.; O.T.; S.T. initial and D/C plan~~

~~4. A separate file folder is used for signed discharge summaries and is to be filed ASAP.~~

~~5. A box is kept for discharge summaries recently received from Transcription that needS to be signed by M.D. This procedure makes unsigned discharge summaries easily assessable when M.D.s come in.~~

### Filing of Loose PHI documents: Discharge Summary, History and Physical and Advance Directives.

- Update the deficiency system
- File the loose PHI documents into the medical records, following the chart order
- Give to File clerk any loose PHI documents that does not currently have a medical record filed on the Physician Completion shelves

#### **IV. PULLING OF CHARTS MEDICAL RECORDS FROM PHYSICIAN COMPLETION SHELVES**

A. Charts Medical records are pulled from the shelf when requested by caregivers the physician or other requestors, so that they either by phone or in person for those who wish to may complete their his/her deficiencies.

1. When a request by phone is received, the charts should be pulled and put on the Incomplete incomplete Physician Competion work tab! shelf with the providers name written on a pull sheet paper and placed on top of charts medical records. e with the person's name or unit # written on sticky paper on top of charts prior to the arrival of the caregiver.

~~2. Frequently, caregivers request charts that are not located in the Incomplete Section.~~

~~3. Charts are pulled once or twice a week for units M-5 and M-7 to be delivered to the head nurses (by the file clerk) for completion of deficiencies; these two units are the only exception. All other head nurses are required to complete their charts in Health Information Services.~~

4-2. Incomplete charts are routinely pulled for each evening/weekend physician to complete their deficiencies. Refer to night/weekend physician schedule to determine who will be working that weekend and the schedule is revised monthly.

5-3. It is recommended that night/weekend physicians' deficiencies are also tagged with yellow sticky paper note with M.D's. name showing. This allows the M .D. to locate the his or her deficiencies easily and helps to insure correct the completion of the correct deficiency by the correct physician.

6.4. Once the medical records has been pulled, and tagged and all outguides are made outchecked signed out/relocated, using the Chart Locator System, out to the Medical Staff Lounge, where the incomplete records are placed for physicians to access and make their corrections/complete the records. and delivered to Medical Staff Lounge correctly (see Outguide Section), the charts are then delivered either to the Medical Clinic's M.D. room desk present that particular evening.

7.5. Weekend doctors: The same procedure is followed as in #6.54 but there are usually more doctors-physicians to pull charts for on Friday, Saturday, and Sunday evenings and on extended holiday weekends.

### Night and weekend Physician's – Send Charts to Medical Staff Lounge

#### Consultants – Send charts to Outpatient Clinic.

\*\* Every Friday, send all medical records for the Friday, Saturday and Sunday N/W scheduled Doctors and also send medical records a day prior to holiday/s for holiday/s.

### V. CHARTS-MEDICAL RECORDS RETURNED TO PHYSICIAN INCOMPLETION DESK

A. All charts-medical records that go are sent out to be completed by units M-5, M-7 attending physicians and night/weekend doctors-physicians or any incomplete charts-medical records taken out of the HIS department for completion must be returned to the Incomplete-Physician Completion Desk.

1. It is important that these charts-medical records that are returned, are checked for completion and then crossed off and dated on the caregiver's index card and also on the yellow incomplete deficiency form in the chart. updated in Chart deficiency module, **immediately.**

#### Deficiency look up for individual providers:

- Log in to the Chart Deficiency module. (Figure 1)
- Click on Provider. (Figure 2)
- Add Visit (Default Today's Date) if a provider completes all or some of his/her deficiency charts.

### VI. OUTGUIDES

A. Outguides are used when a person or persons request to take a chart out of Health Information Services and is used as a tracer by Health Information determining the location of a chart. When a provider request to take a chart out of Health Information Services, charts are checked out in chart locator module and out

guide is printed and placed in the chart. When the chart is returned the printed copy is pulled from the chart.

- ~~1. These guides are to be filled out completely before any chart is to be taken out.~~
- ~~2. It is essential to also write all volumes of the patient's charts on the outguides taken out.~~
- ~~3. Fill out Outguides Slip Completely~~

Example:

Name: Doe, John

Date Requested: 3/1/91

M.R. # 06-52-19 Volumes 1, 2 & 3

Date to be returned: 3/4/91. Initial: MS

(the person filling out the form)

**NOTE:** Each chart taken out should be returned to Health Information Services within three days.

- ~~4. The white original and yellow copy of the outguide slip goes to the file clerk to be filed in the tickler file.~~
- ~~5. The pink copy goes in the pocket outside of chart going out.~~
- ~~6. The green copy goes in a plastic outguide pocket to be filed at exact place where chart was retrieved.~~
- ~~7. When charts are returned, the pink copy is pulled and the green copy is retrieved and then given to the file clerk.~~

#### **VII.VI. REVIEW OF NEWLY-COMPLETED CHART**

A. This procedure is done to determine if a chart medical record is complete ~~and ready for coding~~. A completed chart medical record should have all of its deficiencies completed ~~and all previous missing papers should be in the chart~~. If one deficiency remains incomplete, the medical record is still incomplete.

- ~~1. If clinic notes are missing, a copy is made off the file in the computer and re-routed to be signed by consultants. This is usually done after original signed copy has not been received and is not in clinic notes file.~~
- ~~2. Once chart is determined to be completed, the yellow deficiency form is stamped "completed" and the back of the face sheet deficiencies "completed" stamp is dated and initialed.~~
1. Charts Medical records that have been completed and reviewed re-analyzed are then filed in the coding section PERM section of the HIS department. This process is known as the Close Chart Process.

#### **VII. ~~WEDNESDAY WEEKLY TABULATION REPORT OF~~ INCOMPLETE/DELINQUENT SNF/DELINQUENT SNF MEDICAL RECORDS & ACUTE CHARTS MEDICAL RECORDS REPORTS ARE PRINTED ~~ON~~ BY THE PHYSICIAN COMPLETION UNIT:**

**1. ~~Incomplete Statistics~~ INCOMPLETE MEDICAL RECORDS STATISTICS:** Incomplete statistics are printed in the beginning of the month.

Five copies are made of the Incomplete Medical Records Statistic reports and distributed as follows:

1. Incomplete Desk Binder
2. Chief Medical Officer or Designee
3. Chair of Medical Records Committee
4. Director of Health Information Services
5. HIS designee for Medical records Committee.

The Incomplete Medical Records Statistics are printed from using the Deficiency Reports module which is located in the under Chart Deficiency section, in the under MEDREC Millennium Software.

**TO PRINT THE REPORTS:**

- Find and select the Click Provider Name
- Click Select the Provider Delinquency Summary
- Print the Incomplete Medical Records Statistics reports for: Acute and SNF: Attending, Consultant and Night and Weekend Physicians.

**2. DEFICIENCY LEVEL REPORT:**

The Deficiency Level Report is printed every Tuesday of the each week.

The Deficiency Level report is printed by using the Deficiency Reports module, which is located in the Chart Deficiency section, in the MEDREC Millenium Software.

**TO PRINT THE REPORTS:**

- Select the Provider name
- Select the Deficiency level report.

~~3 (Three)~~ (3) copies are made and distributed as follows:

- Incomplete Desk Binder
- Chief Medical Officer or designee
- Director of Health Information Services

The Deficiency Level report is printed from Deficiency Reports module under chart deficiency under MEDREC Millenium Software.

To Print the reports



[Click Provider](#)

[Click Deficiency level report.](#)

**3. DETAILED CHART MEDICAL RECORD LIST:** Detailed [medical records chart](#) list is printed every Tuesday of the week for acute [medical](#) records and pending discharge summaries.

[The](#) Physician's are notified ~~via~~ [by either: a page, a phone call or email](#) regarding incomplete records and pending discharge summaries. [The r](#)Report is filed in the Incomplete Desk Binder. Communication tracking form is updated and filed [at the or Physician Completion Incomplete Desk.](#)

~~A. This report is a breakdown of all charts that have not been completed including those that have become delinquent and are all separated into SNF and acute categories.~~

~~A report is done on Wednesday of every week on the computer and the date is changed accordingly.~~

~~The first section is done according to physicians. The first page lists all attending physicians alphabetically showing each physician's total incomplete and delinquent charts outstanding for SNF and acute units.~~

~~The second page of the physician's section is an alphabetical list of all other physicians—consultants and night/weekend physicians. The grand total is shown for all physicians.~~

~~The third page is the ancillary section divided by departments and shows totals of all incomplete and delinquent charts, SNF or acute for each department. A grand total is shown for all departments.~~

~~When a physician or ancillary department has not responded to his Friday letters received informing them of delinquent charts to be completed within 2 working days, a notification letter is sent to the chairman of Medical Records Committee for physicians and to the physician who is delinquent; Director of Nursing for nursing and department heads of the various ancillary departments. Copies of these letters are kept in file notebook at the Incomplete Desk.~~

~~1. One copy of the Wednesday Weekly Report is distributed to: Executive Administrator; Chairman of Medical Records Committee; Director of Nursing; Medical Director; Director of Health Information Services; and a copy goes to notebook file at Incomplete Desk.~~

~~2. In the following week if a delinquent record has still not been done following a notification letter sent by the Chairman of the Medical Records Committee, the Director of Health Information Services needs to be notified.~~

~~3. See attached example copy of the Wednesday Weekly Report and an example copy of a final Notification letter.~~

## VIII. ~~FRIDAY~~ INCOMPLETE/DELIQUENT LETTERS

### NOTIFICATION LETTER:

[Letters are distributed to the Physicians every other Friday. Each letter lets serves as notification to the Physician of the know the total number of incomplete medical records and for if applicable, the total number of delinquent medical records charts that need to be completed.](#)

Letters are printed from using the Letter Writer Module in Chart completion section of our under MEDREC Millennium system.

### **PROCESS TO PRINT LETTERS IS AS FOLLOWS:**

- Select Click File
- Select Click Open Letter
- Select and open: SNF\_WEEK.LW2
- Select Click on Selection Criteria
- Select Click on Dept./Rank/Specialty
- Choose the appropriate Dept. for which letters need to be printed
- Select Click ok
- Select Click File
- Select Click on Print Letters

~~Letters are distributed to physicians, nurse and all ancillary departments every Friday. Each letter lets the caregiver know the total incomplete and/or delinquent charts that need to be completed within two working days from date of letter. The totals are added from each index card of the caregiver. The patients' medical record numbers are written on all physicians and nursing letters as copied from each individual index card. On all other ancillary departments letters in addition to the patients numbers written, the patient's name and a description of the deficiency should also be written out. This assists the caregiver in determining what needs to be done and/or what papers he/she needs to bring to the Health Information Services Department.~~

## **IX. RETIRING OF INCOMPLETE MEDICAL RECORDS**

For the medical records that have been incomplete for extended periods of time and the physician is no longer working at LHH, that medical record(s) are eligible to be retired incomplete. The record is listed on the Request to Retire Incomplete list and presented at the Medical Record Committee meeting. The list is reviewed by the Medical Record Chair who may ask why a record or records are being retired

### **RETIRE PROCESS:**

1. Complete deficiency/deficiencies in the PLUS System
2. Complete a Retire Card
3. Attach the written statement from providers and the missing documentation report form for retiring a medical record due to missing documentation, if appropriate, to the back of the Retire Card

4. In an excel file, there is a spreadsheet that is used to document records to be retired incomplete. List the required information in the **MRC RETIRE** (Excel document), located in L drive, for the next Medical Record Committee Meeting
5. Print the list of request to retire incomplete medical records for MRC meeting and provide to the HIS Director.
6. Provide a copy of the list for the Chair of the Medical Record Committee to review during the meeting.

If authorization to retire a medical record incomplete is granted, the following process is performed by HIS:

**CLOSE CHART PROCESS:**

1. Review entire medical record to ensure that all required documents are in medical record.
2. Complete the last deficiency in Chart Deficiency module.
3. Check the CL System, to verify that the chart location has been changed to “PERM”
4. File the closed medical record on the PERM shelf

~~Most recent review: 08/2008, 08/2009, 06/2015~~

Revised: ~~2009/08/10/2009, 2015/6/19/2015~~

Original adoption: 1992/07

## DISCHARGE PROCESS

### ACUTE VS SNF RECORDS:

#### POLICY:

~~1.~~ Laguna Honda Hospital and Rehabilitation Center, ~~a distinct part skilled nursing facility,~~  
~~will maintain~~ a separate unit records for ~~both the~~ Acute patients and SNF residents.

#### PURPOSE:

1. To maintain accuracy in reporting for each patient type.
2. Provide clear documentation for each appropriate level of care.

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#### PROCEDURE:

1. Laguna Honda Hospital and Rehabilitation Center maintains two different levels of care: Acute and SNF.
  - The Acute ~~Wards-Units~~ are ~~M7-LAM~~ (Medical) and ~~L4A-LAR~~ (Acute Rehabilitation).
  - The SNF ~~wards-Units (see attachment)~~ S-2, S-3, S-4, S-5, S-6, NM, N1, N2, N3 N4, N5 AND N6 ~~are all remaining units.~~
2. Each patient/resident's medical record shall be closed and a new record initiated when a patient/resident is transferred from one level of care to another within the facility.
3. Because of our exempt Rehabilitation unit, patients being discharged to or from ~~M7-LAM~~ to ~~L4A-LAR~~ must have their medical record closed and a new medical record ~~one~~ opened for each episode of care.
4. Each patient/resident will be assigned a unique ~~episode~~ episode (ACCOUNT) number for each admission.

Most recent review: ~~08/2008, 08/2009, 6/2015~~

Revised: ~~2009/08/10/2009, 2015/06/19/2015~~

Original adoption: [1986/08/1986](#)

[P.1 of 1](#)

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**DRG CODING**

(In Revision Process May 2010)

**PROCEDURE MS-DRG ASSIGNMENT:****POLICY:**

4. Health Information Services Department shall be responsible for coding all discharge diagnoses for acute inpatient discharged charts reimbursed by a DRG Medicare Severity Diagnosis Related Groups (MS-DRG) payment using ICD-9-CM codes.

**PURPOSE:**

4. To determine the correct Diagnostic Related Group (DRG MS-DRG) on all acute care Medicare inpatient records. To provide codes in a timely manner that are acceptable for billing purposes. To provide accurate, relevant and timely coding. The coding has an impact on billing, indices and statistical reports.

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**PROCEDURE:**

A DRG MS-DRG chart is any chart reimbursed under the prospective payment system by a DRG MS-DRG payment and usually requires a DRG Attestation sheet. Is this still true? The payors are acute care Medicare patients.

**1. Procedure Set DETERMINING MS-DRG PROCEDURE SET I**

- a. DRG MS-DRG charts are coded following all current HCFA Center for Medicare and Medicaid Services (CMS) regulations. Please refer to these regulations CMS for specific guidelines.
- b. The American Hospital Association (AHA) Coding Clinic® updates and errata are is to be used as reference resource. Coding Clinic® provides official coding advice and official coding guidelines, which is recognized and approved by CMS for Medicare reimbursement, as well as many other health care plans. and will be considered the most current instruction and information.
- e-b.
- d. At the end of the month print a copy of the Discharge Register for Acute by Discharge date for the acute ward (M7).
- e. Prepare and label a folder for the month to place photocopies of completed face sheets and discharge summaries of the acute ward (M7).

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**Health Information Services Policy & Procedures**

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Revised: ~~AUG 2009~~ June 2015, June 2015

- ~~f.~~ Fill out the Discharge List worksheet for the month using information from the Discharge Register for Acute by Discharge Date order. List the patient names by discharge date order. Also list the admission date and financial class of each patient.
- ~~g-c.~~ DRG charts should be coded before other records that are of a different financial class.
- ~~d.~~ To determine the principal diagnosis. ~~†The principal diagnosis is~~ should be the condition established after study, to be chiefly responsible for occasioning the admission of the patient to the acute ward of the hospital for care.
- ~~h-e.~~ If the principal diagnosis ~~written by the attending physician on the face sheet~~ is different from what ~~was discussed~~ documented in the medical record as reason for admission after study, the coder will consult with the physician to clarify the diagnosis associated with the reason for admission.
- ~~i-f.~~ If there are two principal diagnoses, select the diagnosis code that is associated with the most resources used associated with that diagnosis during the patient's stay, giving a higher reimbursement as principal.
- ~~j-g.~~ Determine ~~other~~/secondary diagnoses. These are other conditions the patient was admitted with or acquired during hospitalization requiring treatment or evaluation.
- ~~k-h.~~ Review the medical record for possible major complication or comorbidity (MCC) or complications or and co-morbidities (CC) not clearly identified in the discharge note or discharge summary, but documented in the medical record ~~included in the face sheet~~.
- ~~h-i.~~ Check consultation reports.
- ~~m-j.~~ Check lab reports ~~to~~ for verification of ~~verify~~ infections and type of organisms involved.
- ~~n-k.~~ Check the Nutrition Screening and Assessment record for documentation associated with ~~additional~~ diagnoses such as dysphagia, vomiting and diarrhea.
- ~~o-l.~~ Determine the principal procedure. It is the procedure most closely related to the principal diagnosis.
- ~~p-m.~~ Determine ~~other~~ secondary procedures. Check operative reports, pathology reports, consents, radiology reports and laboratory reports.

- ~~q.n.~~ Do not code SNF diagnoses or diagnosis pertaining to another admission on the acute admission/stay.
- ~~f.o.~~ Do not code diagnoses that are not treated on the acute ~~ward~~ unit.
- ~~s.p.~~ ~~The DRG attestation statement must be complete with the attending physician's signature and date. Any changes made by the physician should be initialed by him.~~
- ~~t.q.~~ Enter the codes and complete the abstracting of the medical record ~~other pertinent information in the~~ into the Coding/Abstracting computer system.
- ~~u.~~ Place a printout of the DRGMS-DRG Calculation Screen in an envelope & send to the Billing department. ~~Attach a copy to the Face sheet and Discharge Summary copy and place in the DRGMS-DRG folder. Note down in the Discharge List worksheet all DRGMS-DRG Calculation Screen copies sent to the Billing Department.~~
- ~~v.~~
- ~~w.r.~~ Write your initial and the day's date in the box for Date Coded/Initials in the Deficiency Check List (yellow form) found in the front of the medical record. Pull out this form and turn in to the supervisor. Initial ~~also~~ and date the stamp marked Completed, Coding & Abstracting found on the back of the face sheet.
- ~~x.s.~~ File the completed medical record in the file room and place the incomplete record (record with current deficiencies) in the Physician Completion area of HIS, after relocating the record in the Chart Locator system to the appropriate next destination.

## 2. Procedure Set II PROCEDURE SET II

### Coding completed in Quantim - Need steps from Wen for DRGMS-DRG process ?

Procedure for entering information in the Patient Information System:

- ~~y.~~ Under the Patient Information System (PIS), Medical Records Menu – press PF1.
- ~~z.~~ Under Laguna Honda Hospital Medical Record System – press PF1.
- ~~aa.~~ Enter patient name or medical record number or patient number to retrieve the patient's file.
- ~~bb.~~ Under I/P Medical Records Update Screen, place the cursor next to the patient's name and admission you are to work on. Press Enter.
- ~~cc.~~ Under the Patient's Medical Records Update Screen, select the appropriate Program Function Key to modify medical records data. For acute discharges the Program Functions used are:
- PF 1 – Diagnosis Codes:  
Type in the ICD-9-CM codes from the face sheet. Follow the proper sequence as to the primary, secondary, tertiary and additional codes. Press Enter.



~~PF 2—Procedure Data:~~

~~If a procedure was done during the patient's acute admission, enter the date the procedure was done, the ICD-9-CM code, procedure type, anesthesia type and surgeon identification number. If more than one procedure was done, enter each separately.~~

~~PF 4—Doctor Codes:~~

~~Check if the correct physician's identification number and name is entered for Admitting Doctor, Attending Doctor and Referring Doctor. Add the identification number of consultant, if any, under Consult Doctor.~~

~~PF 5—Additional M/R Data:~~

~~Fill in the Med Service code number, Admission Source code, Admission Type code, Discharge Status code, Discharge Type code number of consultations, Financial Class code, Race code, Autopsy Performed (Y or N for yes or no), Coroner Case (Y or N for yes or no). Press Enter.~~

~~PF 7—**DRGMS-DRG** Calculation:~~

~~Check if all information is correct. Note the **DRGMS-DRG** number and write down in the face sheet in box marked Final **DRGMS-DRG**. Print two copies of the **DRGMS-DRG** Calculation Screen. Press PF 1 to update the patient record.~~

~~Note: Only the patients whose financial class is Medicare need a **DRGMS-DRG** Calculation.~~

~~Press **PF 16** to end the program~~

~~Most recent review: 08/2009~~

~~Revised: 2009/08/10/2009, 2015/06/24~~

~~Original adoption: 1986/08/1986~~

**DRG CODING**  
**MEDICARE ADMINISTRATIVE CONTRACTOR (In Revision Process May 2010)**  
**CMRI MAC REVIEW:**

**POLICY:**

~~4.~~ The Health Information Services Department of Laguna Honda Hospital shall make available the medical records of discharged patients to the ~~California Medical Review, Inc.~~ **MAC (MediCare administrative contractor)** representative for review.

**PURPOSE:**

~~4.~~ To comply with Federal regulations.

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**PROCEDURE:**

The review of the medical records are done in two ways:

- A. On-site - medical records are reviewed in the HIS Department by a representative from **CMRI MAC**.
- B. Off-site - photocopies of the medical records are mailed to the ~~CMRI office~~ **MAC**.

**1. On-Site Review of Medical Records** ~~N-SITE REVIEW OF MEDICAL RECORDS~~

- a. Upon receipt of the ~~Survey Notice from CMRI,~~ prepare internal outguides for each medical record requested. ~~If the medical record number is not on the Survey Notice check the Patient Information System or patient (active and inactive) card file.~~ Notification locate records and check out to appropriate location.
- b. File the Survey Notice in the ~~CMRI binder~~ **MAC binder** in reverse chronological order. Scan the letter and email to CEO, COO, CFO, CMO, compliance, Billing Department. Save the Letter to Compliance drive.
- ~~e.~~ Pull the medical record and check out in chart locator to release of information desk. ~~replace with the outguide.~~ And enter in correspondence management.
- d.c. ~~e.~~ If there is more than one admission in the chart, prepare a temporary folder for the specific record to be reviewed. Write down the patient's name, medical record number, admission date and discharge date on the front of the folder.
- f. ~~Lift out the requested admission from the permanent chart and replace it with canary colored bond paper marked CMRI. All other admissions are to be left in the permanent chart.~~
- g. ~~Securely fasten the chart to be reviewed in the temporary folder.~~

~~h. Place both the permanent chart and the temporary folder in the shelf marked CMRI.~~

~~i.d. When the reviewer arrives, ask for id give only the temporary folder and direct her to a suitable desk to review the chart(s). and to direct to suitable desk.~~

~~j. After the review, update correspondence management and file back the records to appropriate location. the contents of the temporary folder in the permanent chart replacing the canary color bond paper.~~

~~k.e.~~

~~l. Discard the temporary folder and canary bond paper.~~

~~m. File back the chart replacing the outguide.~~

**2. Off-Site Review of Medical RecordsICAL RECORDS**

a. Upon receipt of the notification of the MAC letter locate records and check out to appropriate location. ~~Survey Notice from CMRI, prepare internal outguides for each medical record requested. If the medical record number is not on the Survey Notice, check the master patient index in the computer.~~

b. File the Survey Notice in the ~~CMRI~~MAC binder in reverse chronological order. Scan the letter save to R: drive and email the CEO, CFO, COO, CMO, compliance and billing department.

~~c. Pull the medical record being requested and replace with the outguide.~~ Check out in chart locator and enter the request in correspondence management.

~~d.~~

~~c.~~

~~a. Proceed to photocopy the specific admission requested from the chart. Records from other hospitals are not to be photocopied. Make sure the patient's name and medical record number are shown on each page of the copies. Make sure the photocopies are legible. Enter in correspondence management the documents to be sent out.~~

~~d.~~

~~b. Count the photocopied pages. Double sided copies are counted as two copies.~~

~~e.~~

~~c. Multiply the total number of pages with \$ .0498-10 to get the photocopy reimbursement amount and print Invoice from correspondence management and attach to the copies to be mailed.~~

~~d. Proceed to fill out the CMRI Invoice Photocopying Charges form and the CMRI Invoice Attachment form. The forms are to be filled out for each record requested. (See attachments.)~~

~~\_\_\_\_\_  
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~~Co~~

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~~e. Tape the envelope securely and address to MAC. ~~Complete the CMRI Invoice Photocopying Charges form as follows:~~~~

~~\_\_\_\_\_~~

- ~~Date: Type the date the invoice is being completed.~~
- ~~Invoice #: Type the invoice number.~~
- ~~Hospital/HMO/CMP: Type Laguna Honda Hospital.~~
- ~~Contact Person: Type the name and phone number of the person completing the invoice.~~
- ~~Remit Payment to: Laguna Honda Hospital, Health Information Services, and the hospital address.~~

~~f. Fill out the Postal Service Return Receipt card (green card). Fill out items 1, 3, and 4. Mark Certified for Type of Service. Fill out the sender's name and address (Laguna Honda Hospital) on the other side of the card with attention to the contact person. Attach this card to the back of the envelope over the sealed opening.~~

~~g. Fill out the address part on the Receipt for Certified Mail. Detach the lower portion and attach to the upper left hand side of the envelope. Attach the upper portion to the corresponding MAC forms in the binder.~~

~~e.~~

~~f. For billing inquiries contact: Type the name of the HIS department administrator and phone number. Type the total number of pages, photocopy reimbursement amount and total reimbursement amount on the spaces provided.~~

~~g. Complete the CMRI Invoice Attachment form as follows:~~

- ~~Hospital/HMO/CMP: Type Laguna Honda Hospital.~~
- ~~Reference: Invoice #: Type the invoice number.~~
- ~~Records Request Date: Type the month and year on the Survey Notice letter. Type the Patient name, HIC number, Admission Date, Discharge Date, Number of pages and Total pages on the appropriate spaces. Leave Postage Charges blank.~~

~~h. Photocopy the CMRI Invoice Photocopying Charges form and the CMRI Invoice Attachment form. File the copies in the CMRI binder and place the original in an envelope together with the photocopies of the chart. Use one envelope for each medical record.~~

~~Tape the envelope securely and address to CMRI.MAC.~~

~~Fill out the Postal Service Return Receipt card (green card). Fill out items 1, 3, and 4. Mark Certified for Type of Service. Fill out the sender's name and address (Laguna Honda Hospital) on the other side of the card with attention to the contact person. Attach this card to the back of the envelope over the sealed opening.~~

~~i. Fill out the address part on the Receipt for Certified Mail. Detach the lower portion and attach to the upper left hand side of the envelope. Attach the upper portion to the corresponding CMRI.MAC forms in the binder.~~

~~Place the envelope in the outgoing mail basket.~~

~~f. —~~

~~g-h. Place the envelope in the outgoing mail basket~~

Most recent review: 08/2009

Revised: 2009/08/10/2009

Original adoption: 1986/0808/1986

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## TRANSCRIPTION SERVICES

### FORMAT:

### POLICY:

—All reports shall be transcribed in a standard format.

### PURPOSE:

To ensure ease of reference and efficiency of processing.

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### PROCEDURE:

I. **All Reports Shall at a Minimum Contain:**~~LL REPORTS SHALL AT A MINIMUM CONTAIN:~~

- A. Patient Name
- B. Medical Record Number
- C. Date of ~~Report~~ Service
- D. Date Dictated
- E. Date Transcribed

II. **The Following Additional Reports Shall Have the Following Additional Elements:**~~HE FOLLOWING ADDITIONAL REPORTS SHALL HAVE THE FOLLOWING ADDITIONAL ELEMENTS:~~

**A. Standard Reports**

1. History & Physical

- A. Physician's Name
- B. Special Instructions
- C. Patient's Name (spell)
- D. Unit
- E. Medical Record Number
- F. Account Number
- G. Date of Birth
- H. Date of Admission
- I. Identifying Data
- J. Source
- K. History of Present Illness
- L. Past Medical History
- M. Medications on admission
- N. Allergies
- O. Habits

- P. Past Surgical History
- Q. Social History
- R. Family History
- S. Review of Systems
- T. Physical Examination
- U. Functional Status/ADL
- V. Laboratory
- W. Healthcare Maintenance (includes PPD status and Immunizations)
- X. Assessment/Diagnosis
- Y. Plan
- Z. Discussion Paragraph (mandatory) must include:
  - a. Patient Informed of Diagnosis
  - b. If patient is unable to sign, please dictate reason (if assessed on admission)
  - c. Rehab Potential
  - d. Discharge Plan

27. Advanced Directives

- a. Physician's Name
- b. Special Instructions
- c. Patient's Name
- d. Ward
- e. Medical Record Number
- f. Date of Birth
- g. Date of Admission
- h. Identifying Data
- i. Source
- j. HPI
- k. Functional Status/ADL
- l. PMH (includes meds on admission, allergies, habits, past surgical history)
- m. SH
- n. FH
- o. ROS
- p. PE
- q. LAB
- r. Assessment/Diagnoses
- s. Plan
- t. Discussion Paragraph (mandatory) must include the following:
  - i. Patient informed of diagnosis
  - ii. If patient unable to sign please dictate reason (if assessed on admission)
  - iii. PPD status
  - iv. Rehab potential
  - v. Discharge plan

**u. Advance Directives**

## **B. Discharge Summary:**

1. Physician's Name
2. Special Instructions
3. Patient's Name (spell)
4. Unit
5. Medical Record Number
6. Account Number
7. Date of Birth
8. Date of Admission
9. Date of Discharge
10. Discharge Physical
11. Allergies
12. Hospital Course: includes reason for discharge; consider including summary of problems with lab, x-ray focused exam by problem, immunization status, and past medical history as appropriate.
13. Functional Status at discharge
14. Advance Directives.
15. Disposition of Case (includes medications to be continued and medical or other follow-up).
16. Discharge Medications
17. Discharge Diagnosis (mandatory)

### ~~4. Doctor's name~~

~~Special Instructions~~

~~Patient's name~~

~~Ward~~

~~Medical Record Number~~

~~Date of Birth~~

~~Date of Admission~~

~~Date of Discharge~~

~~Admission/Physical (mandatory)~~

~~Hospital Course: include reason for discharge; consider including summary of problems with lab, X-ray, focused exam by problem, immunization status, and past medical history as appropriate.~~

~~Functional status at discharge~~

~~Advance Directives~~

~~Disposition of case (include medications to be continued and medical or other follow-up). If the patient is being discharged back to SNF, please indicate which ward the patient will be returning to.~~

~~Discharge Diagnoses~~

## ~~C. Clinical Reports~~ **C. Clinic/Consultant Report-REPORTs**



1. Physician's Name (please spell if you are a Resident)
2. Name of Clinic
3. Patient's Name (spell)
4. Unit
5. Medical Record Number
6. Account Number
7. Date of Birth
8. Date of Service
9. Referring Physician
10. Allergies
11. Body of Report
12. Diagnosis/Impression
13. Recommendations

**D. Annual Assessments:**

1. Physician's Name
2. Special Instructions
3. Patient's Name (spell)
4. Unit
5. Medical Record Number
6. Account Number
7. Date of Birth
8. Date of Admission
9. Original LHH Admission Date
10. Date of Last Review
11. LHH Primary Care Physician
12. Source
13. Brief History
14. Allergies
15. Current Medications
16. Active Medical Issues and Problems
17. Past Medical History Not Active since Last Review
18. Social and Emotional History
19. Review of Systems
20. Physical Examination
21. Pertinent Diagnostic Studies
22. Healthcare Maintenance (indicate if patient refused or not indicated secondary to quality of life issues; includes TB status and Immunizations)
23. Current Activities of Daily Living/Functional Status

- 24. Skilled Nursing Facility Needs (optional if time allows)
- 25. Long Range Goals/Rehab and/or Discharge Potential
- 26. Cognitive Assessment
- 27. Current Mental Health Status
- 28. Annual Impression and Plan
- 29. Plan of Care for Ongoing Problems and Active Issues
- 30. Competency to Make Decisions

Advance Directives

- 1. Doctor's Name
- 2. Name of Clinic
- 3. Date
- 4. Patient's Name
- 5. Ward
- 6. Medical Record Number
- 7. Body of report

**D. Radiology**

- 1. Doctor's Name
- 2. Patient's Name
- 3. Ward
- 4. Medical Record Number
- 5. Date of Birth
- 6. Referral Physician
- 7. Body of Report

Most recent review: ~~08/2008, 08/2009, 07/2015~~

Revised: ~~2009/08/10/2009, 2015/07/2015~~

Original adoption: ~~2003/05/19/2003~~

## TRANSCRIPTION SERVICES

### PRODUCTION STATISTICS:

#### POLICY:

Production statistics shall be maintained for each transcriptionist. (This data is run in Webmedx).

#### PURPOSE:

- To ensure that the work standard is being maintained.

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### PROCEDURE:

- ~~Each transcriptionist~~ The expectation is that there is responsible for a daily production of 900 lines ~~line count of 900~~, by each transcriptionist.
- ~~On each report transcribed,~~ The line count will be documented calculated for each report that is transcribed.
- ~~All reports transcribed will be logged and the following elements captured:~~ This data can be captured under Management reports, Trans line log and Trans Line volume, time frame is 7 days in Webmedx system.

~~A. Central Transcription Activity Report~~

~~The types of reports are recorded that may be for each transcribed report are:~~  
~~daily, such as:~~

1. Discharge Summary
2. History & Physical
3. Annual Assessment
- ~~Clinics~~
4. Consultation Report

~~B. The line count for each type of report is totaled for each transcriptionist.~~

~~C.B. The number of reports transcribed by each are recorded for each transcriptionist is available from the transcription system.~~

C. Monthly Seven day or Daily Statistics Report Report This data can be captured located under the Management reports tab in the Webmedx

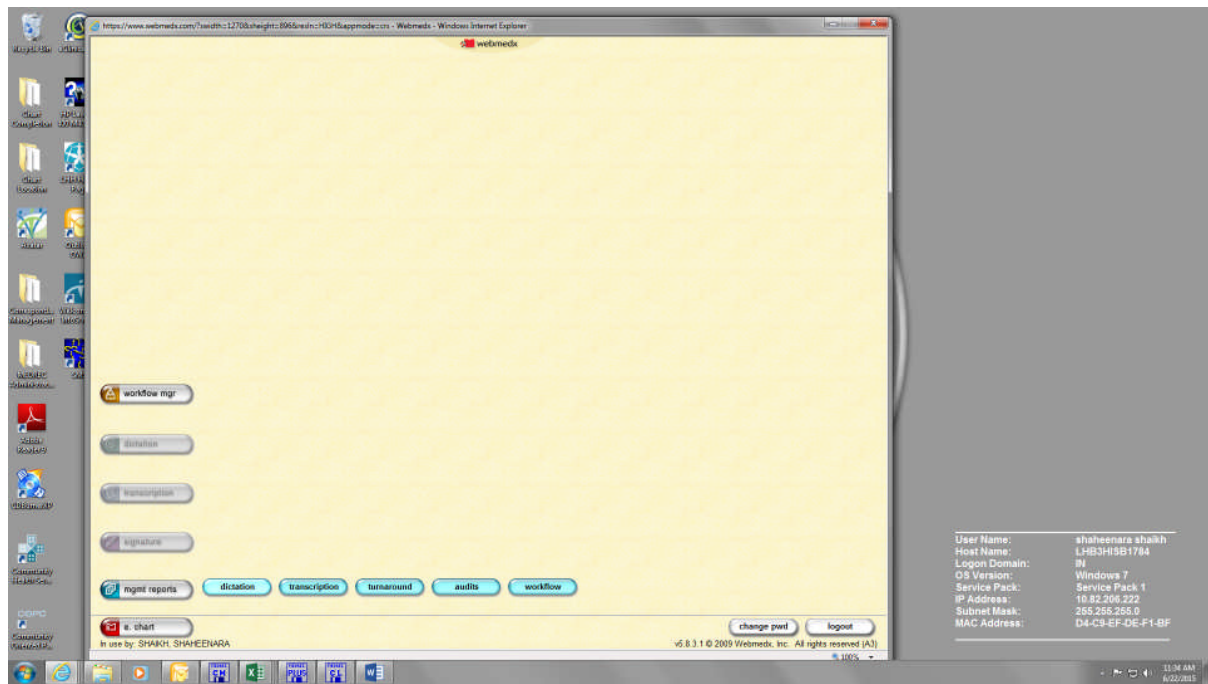
**Transcription system: Trans line log and Trans Line volume, time frame, for a ~~is~~ seven (-7) day-s period, in the Webmedx system.**

- D. Using information recorded from the Central Transcription Activity Report, the line count for the day is totaled for the month for each transcriptionist.
- E. ~~The number of reports transcribed for the month~~ Week or a day are recorded for each transcriptionist.
- F. ~~An average daily line count is calculated for each transcriptionist for the month~~ week.
- G. ~~The average daily line count for the transcription department is recorded for the month~~ week.
- IV. ~~All statistics will be summarized per transcriber monthly.~~
- V. **The ability to transcribe 900 lines per day is based ~~in~~ on the volume of dictation and the availability ~~of dictation.~~**
- VI. ~~Each transcriptionist will be responsible for an equal share of the work load.~~
- VII. Distribution of assignments will may be monitored ~~monthly.~~**
- VIII. Nuance also provides a monthly transcription statistical report via email, for both ~~total number of the transcription done~~ completed by the outside transcription service and in-house transcriptionist of the HIS department.**

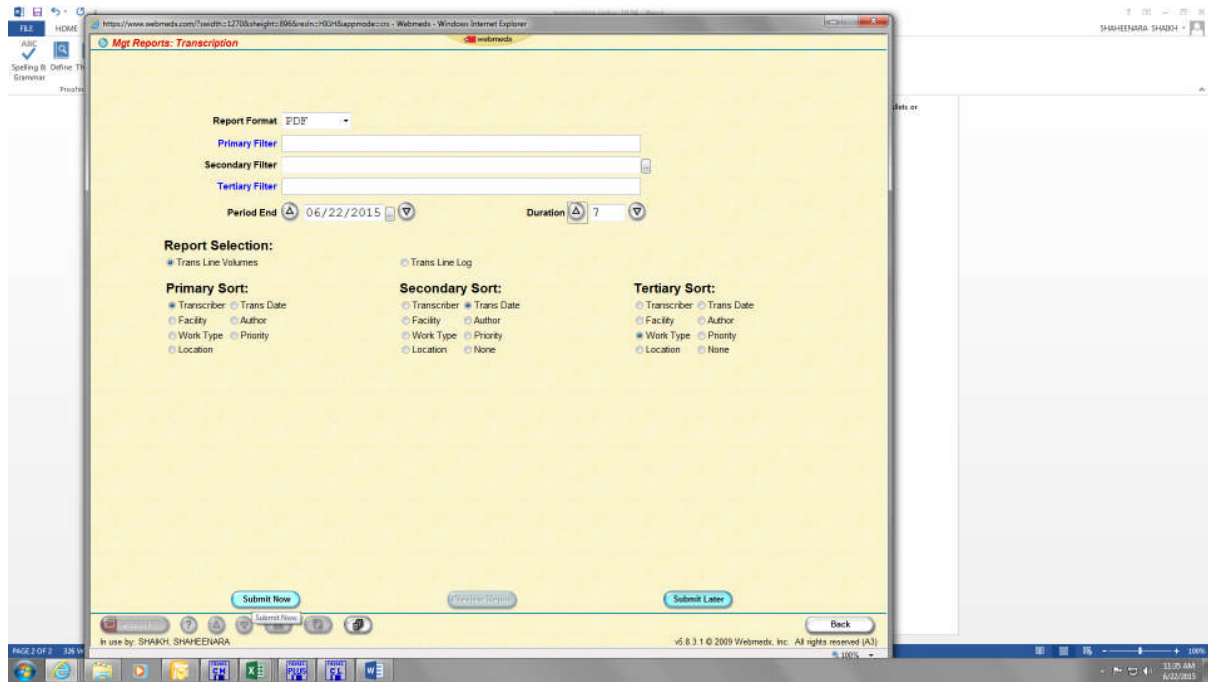
To print the report:

Log in to Webmedx:

Under ~~M~~management ~~R~~report ~~click~~ select on [ Transcription]:



For selection criteria see below: ~~A~~The report can- may be run for a seven (7) day periods only.



Most recent review: [08/2008](#), [08/2009](#)

Revised: [2009/08/10](#)/~~2009-2009~~, [2015/07/6](#)/[1922/2015](#)

Original adoption: [1986/08/1986](#)

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## TRANSCRIPTION SERVICES

### WORK STANDARDS/PRODUCTIVITY:

#### POLICY:

- All transcriptionists ~~must~~ are expected to meet the work established productivity standard as a condition of satisfactory employee performance.

#### PURPOSE:

- To ensure the turn around times are met while processing transcribing dictated reports in a timely manner of accurate, timely reports.

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### PROCEDURE:

- ~~In order to m~~Meet the turn around time established for the various transcribed reports to ensure the availability of the transcribed documents for time-sensitive requirements of patient care. ~~the work standard is 900 lines of acceptable transcription daily.~~
- ~~Acceptable~~ Transcribed reports are expected to be transcription means the production of error-free, ~~reports~~ in the established standard formats for the report type that are properly paginated.
- ~~Work standard includes time for set-up, actual transcription, printout and pagination.~~
- Variation in the quality of dictation, ~~and~~ the type and length of report are taken into consideration when by rotating work assignments to ensure equal work distribution among the transcriptionists.
- ~~Transcribers should routinely take rests between reports.~~

[Policy Number: 10.05](#)

[Revised July 2015](#)

[Most recent review: 08/2008, 08/2009, ~~6/22~~07/19/2015](#)

Revised: [2009/08/10/2009](#)

Original adoption: [1986/0808/1986](#)



## TRANSCRIPTION SERVICES

### CQI:

### POLICY:

Routine and periodic review of dictated and transcribed reports shall be performed.

### PROCEDURE:

To monitor and enhance the quality of documentation materials produced in the process.

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### PROCEDURE:

1. Each report shall be routinely reviewed for the following:

- a. Correct and pProper patient identification.
- b. Adherence to standard formatss.
- c. Proper use of abbreviations and symbols.
- d. Correction of typographical errors, spelling errors, and mistakes in medical terminology.

2. **When errors are identified, ~~on the discretion of the supervisor, the error is corrected and sent to the physician for signature if found after the report has been distributed. Errors are corrected and sent to the physician workqueue for electronic signing in the Wwebmedx Transcription system. The pPerson responsible for performing the deletion of the report in the LCR system is notified of the errored report so that the incorrect report can be deleted from the system.~~**

3. Periodic assessment will be made concerning the following aspects of the dictation/transcription system.

- a. Adherence to processing turn-around times and designated priorities.
- ~~b. Adherence to policies relating to distribution of copies.~~
- b. Down time (scheduled and unscheduled) and
- c. Equipment malfunction time.

Policy Number: 10.06

Revised 2015

Most recent review: 08/2008, 08/2009, 07/2015

Revised: 2009/08/10, 2009 2015/07/21, 6/22 07/21/2015

Original adoption: 1986/08/1986

## STORAGE RETRIEVAL

### RETENTION AND DESTRUCTION OF MEDICAL RECORDS:

#### POLICY:

~~4. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to comply with the Department of Public Health's (DPH) Policy, "Retention Storage and Destruction of Protected Health Information" and retain protected health information in all forms and media for the period of time specified by California statute (7 years minimum) and for longer periods when necessary, for continuing patient care or to meet legal, regulatory or accreditation requirements.~~

~~The schedule of retention and destruction of Medical Records conforms to the State's Statute of Limitations.~~

#### PURPOSE:

~~4.1. The purpose of this policy is to establish a process for the retention, storage, and destruction of protected health information in accordance with applicable sections of The Joint Commission standards, Title 22 of the California Code of Regulations, the Confidentiality of Medical Information Act, and the Health Insurance Portability and Accountability Act (HIPAA).~~

~~To assure that all patient medical records are retained in accordance with accepted professional standards and practices.~~

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#### PROCEDURE:

##### 1. RETENTION OF MEDICAL RECORDS:

##### I. RETENTION OF PROTECTED HEALTH INFORMATION (PHI) Retention of Protected Health Information (PHI)

~~-A. —Protected Health Information (PHI) is retained for the period of time specified by Federal and California statute (10 years recommended).~~

~~B. PHI may be retained for longer periods of time when required by law, when necessary to continuing patient care, or to meet longer retention periods stipulated for minors.~~

~~C. If a DPH facility, division or unit ceases operation or changes ownership, DPH administration and the Department of Health Services will be provided written documentation of arrangements to preserve or transfer all associated PHI.~~

- ~~A) A Medical Record for all patients admitted to Laguna Honda Hospital will be maintained for a minimum period of fifteen (15) years after the patient is discharged. Or, in the case of a minor, three (3) years after the patient reaches majority (18 years old) and not less than fifteen (15) years after the date of discharge.~~

## II. ~~Storage of Protected Health Information~~ STORAGE OF PROTECTED HEALTH INFORMATION

- ~~A. Storage of PHI is maintained in DPH facilities, in secured housing open only to DPH employees. B. Storage of PHI outside of DPH facilities is in approved, HIPAA-compliant facilities with which the DPH has signed Business Associates agreements.~~
- C. Storage of PHI outside of DPH facilities has been approved by the Department of Health Services' Licensing and Certification Division.

~~Medical Records for all patients discharged will be stored (filed) in the Health Information Services file area. Only authorized personnel will be allowed access to the area.~~

## III. ~~DESTRUCTION OF MEDICAL RECORDS~~ PROTECTED HEALTH INFORMATION Protected Health Information:

- ~~A. Destruction of PHI in paper-based formats is accomplished through shredding, radiologic film formats through recycling or as contractually agreed upon with off-site storage vendor.~~
- B. If destruction of PHI in paper-based, radiologic film or digital formats is accomplished through a contractor, it is one with which the DPH has signed Business Associates agreements.
- C. Destruction of devices and/or media storing PHI in digital formats is accomplished through procedures stipulated in DPH HIPAA security policies.

~~A) A permanent, alphabetized record of destruction will be maintained and contain the following.~~

- ~~1. Patient name~~
- ~~2. Medical record number~~
- ~~3. Admission date~~
- ~~4. Discharge date~~
- ~~5. Final diagnosis~~
- ~~6. Method of destruction~~
- ~~7.1. Destruction date~~
- ~~8. Person responsible~~

~~B) Destruction date will be entered on patient index card as a permanent record.~~

↪B) Records containing a problem shall not be destroyed until the problem has been resolved. They will be marked "DO NOT DESTROY" and kept in a secure location until ready for destruction.

~~D)C) Those records stored off-site will be handled through the contractual storage agent, who will destroy all records by shredding and certify their destruction.~~

**-CROSS REFERENCE**

DPH HIPAA Security Policies

Title 22 of the California Code of Regulations

The Joint Commission

Most recent review: 08/2008, 08/2009, 07/2015

Revised: 2009/08/10, 2015/067/295/2015

Original adoption: 2003/5/19/2003

## PATIENT/RESIDENT MEDICAL RECORD

### GUIDELINES FOR ENTRIES:

#### POLICY:

Entries in patient/resident medical records shall be made to reflect each patient/resident's event of care.

#### PURPOSE:

To provide continuity and records that reflect actual episodes of care.

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#### PROCEDURE:

#### PROCEDURE:

— Name, ~~of~~ MR number and DOB on each page, either printed, typed or ~~addressographed~~ addressograph.

4. —

1. —

4. Original document should be in records except for those specific documents approved.

2. —

~~2.3.~~ 3. Factualness and objectivity:

- a. preliminary findings and observations noted as such;
- b. results of studies, tests and evaluations, and actions taken properly noted;
- ~~e.~~ e. ~~freedom~~ Freedom from negative comments about an individual, including patient/resident or family member.

c. —

— Accuracy:

d. —

— legible

—

—

~~e.~~ Legible handwriting or typed.

~~a.~~

~~9.~~ Creation in normal course of patient/resident care: ~~A.~~

~~2.~~ entries made according to standard content;

~~a.~~

~~a.~~ entries made ~~of on~~ approved forms;

~~abbreviations~~

~~Abbreviations~~ ~~limited-restricted~~ to those on ~~the~~ approved abbreviation list.

~~b.~~

~~b.~~

6. Timeliness:

a. documented as close to the time of actual event as feasible;

b. late entries so noted; reason for late entry documented;

~~c.~~ ~~identify~~Identify and clearly note date and time (if appropriate); ~~D.~~

~~e.d.~~ ~~no~~ charting ahead in anticipation of actually rendering care.

7. Freedom from inadvertent or intentional alterations and potential for such altering:

a. continuous entries with no blank pages, lines or spaces;

~~b.~~ ~~line~~Line drawn to end of page when entries do not fill page; ~~G.~~

~~b.c.~~ ~~written~~ in pen with permanent black ink ~~or red for Nursing p.m.;~~

~~e.d.~~ ~~D.~~ ~~error corrections done according to established procedures.~~

8. Authentication:

a. signature on each entry;

b. ~~initials~~Initials or title indicating professional credentials.

~~9-10.~~ Internal Consistency:

a. data entries reflect similar observations of fact as recorded by different disciplines;

b. ~~where~~Where there is a difference of observation and/or interpretation, it should be noted.

10. All entries shall be in Integrated Charting format, with staff beginning in appropriate place. (attachment)

Most recent review: ~~08/2008, 08/2009, 06/2015~~

Revised: ~~2009/08/10/2009, 2015/06/2015~~

Original adoption: [1986/08/1986](#)

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**PATIENT/ RESIDENT MEDICAL RECORD – THIS POLICY IS ADDRESSED IN  
MEDICAL RECORD DOCUMENTATION 01.03. OR DO WE STILL WANT TO KEEP  
THIS.**

**~~CHARTING ERRORS AND / OR OMISSIONS:~~**

**~~POLICY:~~**

- ~~1. Corrections or omission of original entries must be made according to established procedures~~

**~~PURPOSE:~~**

- ~~1. To assure that all errors in the medical record are corrected properly.~~

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**~~PROCEDURE:~~**

- ~~1. Extreme care must be taken in correcting the medical record. Errors noted immediately (nursing notes, for example should be lined through and the correction made immediately following and initialed.~~
- ~~2. Entries must not be erased, crossed out (unreadable) or removed with ink eradicator or similar techniques. Such changes create doubt as to the validity of the entire record.~~
- ~~3. Errors in the medical portion, discovered later, may not be changed but the physician may add a statement to the progress notes giving the desired information, reason for making change, and signing such note.~~

Most recent review: 08/2008, 08/2009

Revised: 2009/08/10/2009

Original adoption: 1994/5/4/1994

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## ~~PATIENT / RESIDENT IDENTIFICATION SYSTEM~~

### ~~PURPOSE:~~

### ~~POLICY:~~

- ~~1. Health Information Services (H.I.S.) shall provide and coordinate a centralized patient/resident identification system. The system shall be comprehensive and based on two premises.~~
  - ~~A. There is a need to know the fact that an individual was brought to LHH for care~~
  - ~~B. There is a need to know the disposition of each case.~~

### ~~PURPOSE:~~

- ~~1. Identification of the patient/resident as a unique individual.~~
- ~~2. ID as a patient/resident of LHH.~~
- ~~3. ID and linkage of documents relating to the care of each patient/resident.~~
- ~~4. Provision of ready access to documentation for authorized use under the storage and retrieval function.~~
- ~~5. Provision of database for statistical information.~~

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~~=~~

### ~~PROCEDURE:~~

#### ~~I. ADMITTED TO LHH~~

- ~~A. An official medical record/database is created, and identifying numbers are assigned.~~
- ~~B. Patient/residents who complete the admission process and leave without being treated will have their admission reviewed.~~

#### ~~II. NOT ADMITTED TO LHH~~

- ~~A. Patient/resident who are dead on arrival.~~
- ~~B. Patient/resident who choose to leave without completing the admission process.~~
- ~~C. No medical record is created.~~
- ~~D. No medical record is assigned.~~
- ~~E. Any information entered in the database is backed out.~~

- F. ~~Any patient/resident admitted and discharged who were on the unit for less than four (4) hours.~~
- G. ~~If a medical record is created it is forwarded and kept in H.I.S.~~

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Laguna Honda Hospital & Rehabilitation Center \_\_\_\_\_ Policy Number: **5.01**  
**Health Information Services Policy & Procedures** \_\_\_\_\_ Revised: AUG-2009

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- H. ~~If the patient/resident is ultimately readmitted, any documentation from the previous encounter is incorporated into the new record with an explanation.~~

### III. **UNIT NUMBER**

- A. ~~Each patient/resident admitted shall receive a medical record number at the time of their first admission to LHH for treatment. This medical record number shall be retained and used for all subsequent admissions.~~
- B. ~~The medical record number shall be a six digit number unique to LHH.~~
- C. ~~The patient/resident will also be assigned a billing number to facilitate identification of a specific episode of care and for billing information.~~
- D. ~~The medical record number will be the official identifier and records shall be stored under this number.~~

### IV. **RESPONSIBILITY FOR PATIENT/RESIDENT IDENTIFICATION**

- A. ~~The responsibility for patient/resident identification will be shared with Admissions and Eligibility, with the primary control and responsibility resting with H.I.S.~~
- B. ~~Assignment of each new patient/resident medical record number will be system generated during the admission process.~~
- C. ~~HIS will be responsible for the control log, carry out error detection, correction and prevention, and maintain the master patient index.~~
- D. ~~Admissions shall obtain full and accurate patient/resident identification data and access the central database to verify that the patient/resident does not have current medical record number from previous admission.~~
- E. ~~The Discharge Processing Unit of HIS shall routinely check the patient resident identification and medical record number on patient/resident records. This shall be carried out as part of the discharge processing, assembly and analysis process. If an error is detected, the technical supervisor shall be notified.~~
- F. ~~All other departments noting an error, discrepancy or omission shall refer the problem to HIS for handling.~~

Most recent review: 08/2008, 08/2009  
Revised: 08/10/2009  
Original adoption: 08/1986

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## PATIENT/RESIDENT IDENTIFICATION SYSTEM

### UNIT NUMBER CONTROL LOG:

#### POLICY:

1. A permanent unit number control log shall be maintained.

#### PURPOSE: —

1. To maintain control of the accurate assignment of patient/resident medical record numbers.

---

### PROCEDURE:

#### I. INFORMATION

- A. ~~A medical record number should be used only once.~~
- B. ~~The control log shall contain the following:~~
  - 1. ~~Medical record number assigned~~
  - 2. ~~Name of patient/resident~~
  - 3. ~~Date assigned~~
  - 4. ~~Date reason number voided~~
  - 5. ~~Block assignment~~
- C. ~~When the face sheet is received for the admissions office, the appropriate information is entered into the control log.~~
- D. ~~In the event a duplicate number has been assigned, the Assistant Director is immediately notified.~~
- E. ~~The Assistant Director verifies information through the MPI and notifies the Admissions Department. The necessary corrections are then made.~~
- F. ~~Voided numbers shall not be re-issued.~~
- G. ~~For ADHC/Radiology outputs clients, a block of valid numbers are assigned and denoted in the control log.~~
- H. ~~The control log is confidential: access is permitted only to authorized users.~~

Most recent review: 08/2008, 08/2009  
Revised: 08/10/2009  
Original adoption: 08/1986

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## TRANSCRIPTIONAL SERVICES

### TRANSCRIPTION DISTRIBUTION:

#### POLICY:

- ~~All information entered into the dictation system shall be transcribed and distributed by Health Information Services (H.I.S.) Transcription Service personnel. The distribution shall be timely and systematic and printed on the unit once the report is transcribed and once signed by the provider.~~

#### PURPOSE:

- ~~To provide timely distribution.~~

#### PROCEDURE:

##### **I. ~~I- DISCHARGE SUMMARIES~~ SUMMARIES: Printed on the unit and Incomplete Desk for all patient types.**

###### A. ~~All wards except M-7/Acute Rehab~~

- ~~Leave all originals on the Incomplete Desk.~~
- ~~Check cc's at the end of page and make the necessary copies. Type envelopes for those copies which need to be sent out of the hospital, and submit to Medico-Legal for recording.~~

###### B. ~~Ward M-7~~

- ~~M-7 discharges to the outside or deaths - make (2) copies: place the original in the doctor's box, (1) copy to U.R., and (1) copy to the DRG Coordinator.~~
- ~~M-7 discharges to other wards - make (3) copies: place the original in the doctor's box, (1) copy goes to U.R., (1) copy goes to the ward where the patient is being discharged to (Ward Box), and (1) copy goes to the DRG Coordinator.~~

###### C. ~~Acute Rehab~~

- ~~Acute Rehab discharges to the outside or deaths - make (2) copies: original goes to the Incomplete Desk, (1) copy to U.R. and (1) copy to the DRG Coordinator.~~



~~2.1. Acute Rehab discharges to other ward – make (3) copies: original goes to the Incomplete Desk, (1) copy to U.R., (1) copy to the ward where the patient is discharged to (ward box), and (1) copy to the DRG Coordinator.~~

## II. HISTORIES AND PHYSICALS

A. Advance Directive report to be ~~cut and clipped to the H & P for sending~~ printed on separate paper titled Advance directive report.

P.1 of 4

### III. SURGICAL CLINIC

~~Make (2) copies: (1) for Surgery (stapled) on white paper and (1) for the ward on yellow paper. Do not erase the tape if there are any questions regarding the dictation. Attach a note stating that the tape has not been erased and the nature of the problem. DO NOT CUT ANYTHING GOING TO SURGERY. Nurse's office (located in the back room on far right). It is best to let nurse know delivery was made. Paper clip originals, stapled copies and flow sheet together and deliver to Surgery along with any erased surgery tapes. If operating room is closed, go to Charge. Whenever possible, reports should be delivered to Surgery before 8:30 a.m. Cut yellow copies unless it is 3/4 of a page or more long, and place copies in ward boxes.~~

### IV. CARDIAC CONSULTATION

~~Make (2) copies: (1) for the cardiologist and (1) yellow copy for ward. Place the original and (1) copy in the cardiologist's box. Place the yellow copy in the corresponding ward box. Check cc's at the end of the report and make the necessary copies.~~

### V. CAST WORK

~~Make (3) copies: (1) for Surgery (stapled), (1) for P.T., and (1) yellow copy for the ward. Deliver the originals (not cut) and one copy (stapled) to Surgery. Place P.T.'s copies in the corresponding box. Place the yellow copy in the appropriate ward box.~~

### VI. ENT Clinic

~~A. Make (3) copies: (1) for Surgery (stapled), (1) copy for Speech and (1) yellow copy for the ward.  
DO NOT CUT ANYTHING GOING TO SURGERY.~~

~~Paper clip originals, stapled copies and flow sheet together and deliver to surgery along with erased surgery tapes. If operating room is closed, go to Charge Nurse's office (located in back room on far right). It is best to let the nurse know delivery was made.~~

~~Cut yellow copies if it is less than 3/4 of a page, and Speech copy to be delivered to the appropriate box. Place yellow copies in ward boxes.~~

#### ~~VII. G.I. CLINIC~~

~~Make (2) copies: (1) for Medical Clinic (stapled) and (1) yellow copy for the ward.~~

~~Clip originals (cut) with the stapled copies and deliver to the Medical Clinic. Place yellow copies in ward boxes;~~

~~Check cc's at the end of the report and make the necessary copies.~~

~~Cut yellow copies if it is less than 3/4 of a page and place yellow copies in ward boxes.~~

~~P.2 of 4~~

#### ~~VIII. G.U. Clinic~~

~~Make (2) copies: (1) for Surgery and (1) yellow copy for the ward.~~

~~DO NOT CUT ANYTHING GOING TO SURGERY.~~

~~Paper clip originals, stapled copies and flow sheet together, and deliver to Surgery along with erased surgery tapes. If operating room is closed, go to Charge Nurse's office (located in back room on far right). It is best to let the nurse know delivery was made.~~

~~Cut yellow copies if it is less than 3/4 of a page and place copies in ward boxes.~~

#### ~~IX. NEPHROLOGY CONSULTATION~~

~~Make (2) copies: (1) for the nephrologist and (1) yellow copy for the ward.~~

~~Paper clip originals with the stapled copies and place in the nephrologist's box located in the Medical Director's office.~~

~~Check cc's at the end of the report, and make the necessary copies.~~

~~Place yellow copies in ward boxes.~~

#### ~~X. NEUROLOGY CLINIC~~

~~Make (2) copies: (1) for the neurologist and (1) yellow copy for the ward.~~

~~Paper clip originals with the stapled copies and place in the Medical Clinic box located in the Nursing Office (Label to: Medical Clinic).~~

~~Check cc's at the end of the report and make the necessary copies.~~

~~Place the yellow copies in the ward.~~

#### ~~XI. ONCOLOGY-HEMATOLOGY CLINIC~~

~~Make (2) copies: (1) for the oncologist and (1) yellow copy for the ward.~~

~~Cut originals if less than 3/4 of a page.~~

~~Paper clip originals with the oncologist's copy and place them in the Medical Clinic box.~~

~~Place yellow copies in ward boxes.~~

#### ~~XII. ORTHOPEDIC CLINIC~~

A. Make 4 copies: (1) for P.T., (1) O.T., (1) for Surgery, and (1) yellow copy for the ward.

As a general rule, no need to cut if 3/4 of the page in length.

**DO NOT CUT ANYTHING GOING TO SURGERY.**

Paper clip originals, (1) stapled set and flow sheet together along with erased surgery tapes, and deliver to Surgery. If operating room is closed, go to Charge Nurse's office (located in back room on the right). It is best to let the nurse know that delivery was made.

Envelope can be found in right hand drawer for the SFGH set.

Address is: San Francisco General Hospital

Department of Orthopedic Surgery, Room 3A-36

1001 Potrero Avenue

San Francisco, California 94110

Attn: Thao Le

Place yellow copies in ward boxes, and the other stapled set in their appropriate boxes.

### XIII. OUTPATIENT REPORTS (O.P.D.)

Make (2) copies: (1) copy for the physician and (1) yellow copy for the ward.

Clip the original to the copy and deliver to the physician's box.

Place yellow copies in ward boxes.

P.3 of 4

### XIV. PHYSIATRY (PHYSICAL MEDICINE)

Make (4) copies (1) for P.T., (1) for O.T., (1) for Speech Clinic (K-4), and (1) yellow copy for the ward.

Originals should be cut, clipped and placed in the P.T. box along with their copies.

Place the other copies in the appropriate boxes, and the yellow copies in the ward boxes.

### XV. PLASTIC SURGERY CLINIC

A. See (VIII) GU Clinic.

### XVI. PULMONARY CONSULTATION

Make (2) copies: (1) for the physician, and (1) yellow copy for the ward.

Paper clip originals with the physician's copy and place in his box.

Check cc's at the end of the report, and make the necessary copies.

Place yellow copies in ward boxes.

### XVII. REHABILITATION CONSULTATION

(See Physiatry XIV.)

### XVIII. SKIN CLINIC

Make (2) copies: (1) for the Medical Clinic and (1) yellow copy for the ward.

Place originals (cut) along with the stapled copies in the Medical Clinic box located in the Nursing Office along with any erased mini-cassettes. (Label to: Medical Clinic.)

Place yellow copies in ward boxes.

### XIX. UROLOGY

Also known as G.U. Clinic.

See (VIII) G.U. Clinic.

~~XX. VASCULAR CLINIC~~

~~A. Make (2) copies: (1) for Surgery (stapled) and (1) yellow copy for the ward.~~

~~DO NOT CUT ANYTHING GOING TO SURGERY.~~

~~Paper clip originals, stapled copies and flow sheet together, and deliver to Surgery along with erased surgery tapes. If operating room is closed, go to Charge Nurse's office (located in the back room on far right). It is best to let nurse know delivery was made.~~

~~Cut yellow copies if it is less than 3/4 of a page, and place yellow copies in the appropriate boxes.~~

Most recent review: 08/2008, 08/2009

Revised: 2009/08/10/2009, 2015/06/09/15

Original adoption: 1994/5/4/1994

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DELETED

REVENUE REPORT - ? SHOULD THIS BE RENAMED

PHYSICIAN SERVICE CHARGES:

POLICY:

All Physician service charges will be captured to facilitate reimbursement.

All physician service charges will be captured to facilitate reimbursement

PURPOSE:

In order to capture all possible revenue for the hospital, Health Information Services will pick up the single encounter forms completed by physician after a bedside visit or face to face encounter with the resident which are placed in the HIS box on the nurses station on the unit. will be responsible for abstracting all documented charge information from each patients'/residents' clinical record.

PROCEDURE:

The unit analyst will be responsible for the insertion of at least 2 physician service charge sheets in the front of each patient's chart. Each charge sheet must contain patient-identifying data which can be obtained by using the addressograph card or printing off the ADL system.

All physicians will be responsible for documenting the following information on the physician service charge single encounter sheets for each patient:

- A. Date of Visit
- B. CPT Code
- C. A diagnosis to justify each visit, lab tests, or procedures
- D. Physician name and/or ID number.

For the routine monthly visits, the physician only need to indicate monthly visit and the first diagnosis listed in the ADL system will be used unless the physician documents another diagnosis. The physician will indicate RMV (routine monthly visit) on the charge sheet.

Physician completes form and places in HIS box on the unit on each station.

HIS Analysts to pick up the completed form weekly on Friday. (Vacation coverage for shared units the backup analyst will pick up the forms. For units that are not shared - ?

Review single encounter form for completion. Incomplete forms with missing written Diagnosis are to be returned to the MD.

Verify the visit, code the diagnosis listed on the single encounter form.

Turn in the Single encounter forms to the coder. Place the single encounter forms with no issues in no issues box and one with issues in Issues box on the coders' desk.

**Single encounter Forms – Coder Instructions:**

Forward/deliver the Single encounter forms with no issues to billing.

Review and validate the ICD diagnosis codes on the forms from issues box.

If an error is discovered with ICD -9 code diagnosis send action to the physician through Ecw - ? Not sure if you would like to keep this process.

- IV. ~~The analyst will review all sheets one week prior to the end of the month, and alert the unit physician of those missing a monthly visit.~~
- V. ~~The unit analyst will be responsible for coding all diagnoses using ICD-9-CM and verifying the following:
 
  - A. ~~All entries are complete and accurate~~
  - B. ~~CPT code used is appropriate~~
  - C. ~~Physician ID number is correct~~~~
- VI. ~~When a procedure is performed, there should be two CPT codes, one for the visit and one for the actual procedure. If the CPT code for the procedure is not recorded by the physician, the analyst will be responsible for entering the correct CPT code onto the charge sheet. For example:
 

Blood Transfusion	_____	36430	_____	99.03
Anemia secondary to blood loss	_____	99233	_____	280.0
- VII. ~~Physician visits entered on the physician service charge sheet for a different month must be crossed off and transferred to the correct charge sheet for the month.~~
- VIII. ~~The unit analyst will be responsible for pulling the physician service charge sheets on the **first work day** of the following month and ensuring that another charge sheet is available for:~~

documentation. If any charts are not available, the analyst will be responsible for returning to the unit to pull the charge sheet.

IX. Analysts who are off on the first work day of the month will have their CPT sheets pulled by the Revenue Support Unit; however, the analyst will be responsible for coding the CPT sheets. The Revenue Support Unit will be responsible for the following:

- A. Pulling and coding CPT sheets for uncovered units, including leave of absence.
- B. Pulling CPT sheets when analyst is on vacation; however, the respective teams will be responsible for coding their team members' units when they are on vacation.

X. After final review, H.I.S. will notify the unit physician a second time if there is still no visit recorded. This will be the last notification prior to submission to Billing.

XI. A list of those patients without a monthly visit will be forwarded to the Medical Director.

XII. The unit analyst will be responsible for including charge sheets on patients who have been discharged during the month.

XIII. The unit analyst will be responsible for verifying that the correct episode number is used for discharges and re-admissions during the same month.

As part of the monthly CCJ monitor, the unit analyst will verify that each visit is documented by reviewing the progress notes. If any required information is missing on the charge sheet, the chart will be flagged for the physician to complete.

XIV. Multiple visits on the same day for the same diagnosis allow for only one visit to be billed. The CPT code for the two visits are then bumped up to the next level. If the second visit is by the Night Physician, the visit will be given to the Attending Physician. (Not applicable if one of the two visits was made by a consultant).

Example A:

8/1/98 Fever Dr. Albion 99311  
=99312

8/1/98 Fever Dr. Tsang 99311

Example B:

8/1/98 Dementia Dr. Albion 99311

8/1/89 Dementia Dr. Baldwin 99261 - STAFF UNABLE TO CATCH THIS DUE TO SINGLE ENCOUNTER FORMS -?

XV. All charge information along with recap sheet and cover sheet will be forwarded to the supervisor of the Revenue Support Unit the first three work days of the month for CQI, i.e. coding, etc. Charge sheets returned to the analyst for correction must be corrected and resubmitted to the supervisor immediately.

XVI.XII. Once the cover sheet is signed by the supervisor, the documents are given to the clerk for sorting and copying before delivering to Billing. All physician service charge sheets must be submitted to Billing by the fifth work day.

~~XVII. Upon receipt of the physician service charge sheets, the Billing Supervisor dates and signs the cover sheet. A copy is made for Billing and the original is retained by **H.I.S.**~~

**DELETE**



Policy Number: **11.01**

Revised: June 2015

Laguna Honda Hospital & Rehabilitation Center  
**Health Information Services Policy & Procedures**

Policy Number: **11.01**  
Revised: **June 2000**

~~XIX. Physician service charge sheets submitted later in the month must be labeled "late entry" on the recap sheet and forwarded to the Billing Department.~~

~~XX-XIX.~~ A monthly statistical report is generated for the Utilization Management Committee, and copies of incomplete CPT sheets are forwarded to the Chief of Staff on a monthly basis. – Under review.

Most recent review: 08/18/2008

Revised: 2000/06

~~/2000~~ Original adoption:

Policy Number: **11.01**

Revised: **June 2015**

Laguna Honda Hospital & Rehabilitation Center  
**Health Information Services Policy & Procedures**

Policy Number: **11.01**  
Revised: **June 2000**

- ~~X. At discharge, the chart will be reviewed by the assigned Ward Analyst in the department to ensure all charges have been captured through discharge.~~
- ~~XI. All charge information will be forwarded to clerk assigned bi-weekly. A recap sheet, along with the original charge forms will be forwarded to billing.~~

Most recent review: 08/18/2008  
Revised: 06/2000  
Original adoption: MWDD/YYYY

## RELEASE OF INFORMATION

### RELEASE OF MEDICAL INFORMATION WITHOUT PATIENT AUTHORIZATION

**POLICY:**

The Hospital must release medical information without written patient authorization under certain circumstances.

**PURPOSE:**

1. To comply with current California and Federal law.

---

**PROCEDURE:**

- I. Health record information is to be released without patient authorization under the following circumstances:**
  - A. By a court order.
  - B. By a board, commission, or administrative agency in response to an investigate subpoena for adjudicative purposes;
  - C. By a party before a court or agency in response to various types of subpoenas authorizing discovery of records.
  - D. By an arbitrator of panel in response to a subpoena *duces tecum* authorizing discovery of records;
  - E. By search warrant;
  - F. When required by law  
(includes various Department of Public Health requests in response to complaints by patients or Medi-Cal or Medicare fraud investigations or Ombudsman Program representatives).
- II. The Hospital may release medical information without written patient authorization under the following circumstances:**
  - A. To providers of health care for diagnosis and treatment of the patient (physicians and hospitals);
  - B. Hospital senior management involved in administrative and fiscal matters.
  - C. To person or entity responsible for payment, to the extent necessary to determine services rendered;
  - D. To agents of professional societies, malpractice insurers, etc., to review competence of health care professionals;
  - E. To private or public body responsible for licensing;
  - F. To county coroner;
  - G. To specified researchers whose project has been approved by the Ethics Committee. Written permission must be obtained from the Medical Director prior to release.

**Health Information Services Policy & Procedures**

Revised: AUG 2009

- H. To a patient's employer only where the information disclosed is from an employment related health service requested and paid for by the employer;
- I. To insurer, group practice or administrator of a group individual or uninsured plan only if information results from health services provided at the written request and expense of the sponsor or with the patient's prior written authorization.

**III. TUMOR REGISTRIES**

- A. Record all inquiries either written or verbal on the correspondence log, or Other Miscellaneous Correspondence Log respectively.
- B. Check to verify if patient is or ever was hospitalized at LHH using:
  - 1. Patient Information System and/or
  - 2. Master Patient Index 9MPI, Active and Inactive
- C. If patient cannot be identified return inquiry to sender with an explanation (see attached form #1 or 2).
- D. Place correspondence in file folder according to date received.
- E. If patient is currently in a unit, locate the unit and forward to the attention of the nurse manager with a note to the physician to complete the form and return to Health Information Services.
- F. Xerox copy of form and place in miscellaneous section of chart.
- G. Log in date sent out.
- H. Send original form to appropriate hospital registry.

**TELEPHONE INQUIRIES**

Ask caller to send a written request for information.

**IV. MEDICARE INTERMEDIATRY – BLUE CROSS OF CALIFORNIA**

Request for records are submitted to Health Information Services from Blue Cross of Ca., Medicare Medical review, P.O. ox 70000, Van Nuys, Ca. 91470, through the LHH Billing Department. All records must be returned to the Medical Review Section at Blue Cross 30 days from the date shown on the top left corner of the request.

- A. Requests are received from the Billing Department with the itemized statement attached.
- B. Check to verify if patient is or ever was hospitalized at LHH using:
  - 1. Patient Information System and/or

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**Health Information Services Policy & Procedures**

Revised: AUG 2009

2. aster Patient Index (MPI), Active and Inactive
- C. Records to be released are indicated on the request.
  1. Check dates to/from
  2. If information is requested regarding URC Notice, send a Xerox copy of the request form to: Utilization Review. This information will be sent back to Medical Record Services.
  3. If Certification for Therapy is requested, complete form (see attached) and forward to PT, OT, Speech as indicated.
- D. Please inquiry in file folder until ready to handle.
- E. If patient is on unit, pick up chart, Xerox information requested and return chart to the nursing station as soon as possible.
- F. For discharge charts, pull from Health Information Services, Xerox records requested and return chart/s to proper location.
- G. Log in information released and date sent out.
- H. Stamp COPY on top of H&P and Discharge Summary.
- I. When all information is received and records copied, prepare for mailing.
  1. Attach original Blue Cross request sheet to the records and itemized billing.
  2. Place in Red Bordered envelope for mailing.
- J. File copy of request according to date. If Psych. Dx. Was indicated, file copy of request in separate file folder.

**V. NOTICE OF DETERMINATION-NON PAYMENT OF SERVICE**

If records for the time period specified were previously requested and sent out or the original request was not received, complete the form (see attached form #6) and sending to the Billing Department.

Most recent review: 08/2008, 08/2009

Revised: 08/10/2009

Original adoption: 08/1986

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## RELEASE OF INFORMATION

### RELEASE OF MENTAL HEALTH RECORDS:

#### POLICY:

Mental Health records are covered by the California Lanterman-Petris-Short Act and include psychiatric notations in the history and physical consultation reports, identify, diagnosis, prognosis or treatment received at the Hospital.

1. Records may be released with the patient's authorization.
2. Records must be released to the court based on a court order, but not released in response to a subpoena duces tecum (see CHA Consent Manual Section 22.3b)

California law has defied stringent confidentiality requirements for making information from a mental health record available. AB-610 states specifically that it is to take precedence over the confidentiality provisions of the Lanterman-Petris-Short Act (California Health and Safety Code) [Section 25252(a)]. Therefore, both patients and representatives will be permitted to inspect and receive copies of psychiatric records under the law.

The statutory provisions do provide exceptions whereby patient records of information may be released without the patient's authorization (see CHA consent Manual Section 22.3a). It is necessary to document all such releases.

In consideration of expressed concerns; however, the law does allow a provider to refuse access to a patient, where the provider determines that there is "substantial risk of significant adverse or detriment consequences to the patient in seeing or receiving a copy" of the records [Section 25253(b)]. The option of denying access applies to requests from the patient only; it does not apply to requests from the patient representative, i.e. a parent, a guardian, or conservator of the person.

#### PURPOSE:

To uphold the confidentiality of health record information.

---

#### I. PROCEDURE:

A. Upon receipt of an authorized written request for patient's mental health records:

1. Determine if the patient has or is currently receiving psychiatric treatment by examining the diagnosis or treatment entries within the patient records.
2. If such entries are found, indicate that the patient has received psychiatric treatment in the remarks section on the log sheet (See Attachment M)
3. Notify the Attending Physician/Medical Director and the psychiatrist/psychologist promptly (first working day after receipt) of any request by a patient to inspect or receive copies of an alcohol and/or psychiatric record. If the Attending Physician is not available, the Medical Director will be notified. The Medical Records Department must be advised no later than the fourth working day if denial is recommended; otherwise access will be permitted. (use of a separate authorization form is required – see Attachment N)
4. There may be occasions when a portion of a record of medical or surgical care includes material relating to the evaluation of treatment of a concurrent mental health problem. The physician has the option of denying access to this portion of the record but not to the record, generally. All the conditions relating to denial of mental health records apply, including documentation of the decision, notification of the patient, and extension of alternative access as described in the law.

- a. The determination to refuse access must be made each time that access is denied. Since the patient's condition will change over time, such determination cannot be made in advance or on a continuing basis.
  - b. The determination should be well considered and denial made only when the adverse consequences are significant and can be described. Routine denial of access because of a generalized concern over possible adverse consequences will not be deemed compliance.
5. If access is denied, the patient has the right to designate a licensed physician, psychologist, or social worker to review the record or obtain copies. If this option is exercised, conditions governing any other access under the law will apply, with the additional requirement of a valid written authorization from the patient for such disclosure. A reasonable effort should be made to verify that the person named is, in fact, a licensed professional. This can be done by telephone or letter requesting confirmation of status and willingness to accept the record.
- a. When denial determination is made, the physician must take the following mandatory steps:
    - i. Notify the patient that access is being refused
    - ii. Inform the patient of the right to designate a licensed physician, psychologist or social worker to review the records or obtain copies.
    - iii. Make a written record of the refusal.
  - b. The written record, which becomes a part of the patient record, must include:
    - i. Date of request
    - ii. Reason for refusal, with an explanation of the adverse consequences anticipated.
    - iii. Whether or not the patient requested that the records be made available to a licensed physician, psychologist or social worker.

## II. ARCH CHARTS

- A. Follow policy and procedures for release of alcohol and drug abuse records.

Most recent review: 08/24/2011  
Revised: 08/24/2011  
Original adoption: 08/24/2011

DELETE INCLUDED IN 13.1



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## RELEASE OF INFORMATION

### RELEASE OF ALCOHOL AND DRUG ABUSE RECORDS:

#### POLICY:

Alcohol and drug abuse records are covered under Federal Regulation and include all information or records of identify, diagnosis, prognosis or treatment received or acquired in connection with an alcohol or drug abuse program.

1. Records may be released with the patient's authorization.
2. Records must be released to the court based on a court order, but not released in response to a subpoena *duces tecum* (see CHA Consent Manual Section 23.3c)

Alcohol and drug abuse records that are subject to federal alcohol and drug abuse regulation (42 C.F.R. Section 2.1 et seq.) may be disclosed only in accordance with the federal regulations (see CHA Consent Manual, Chapter 23.1). These regulations do not give a patient an automatic right to inspect or obtain copies of medical records regarding his treatment for alcohol and drug abuse. Rather, they permit the hospital to release the information upon the presentation of a written authorization by the patient that meets the requirements of the regulations (42 C.F.R., Section 2.31).

Since the patient can, under these regulations, authorize release of information to any individual, it is assumed that the patient can authorize disclosure to himself. The provider may honor such an authorization if the provider determines that such disclosure will not harm the patient or the program's overall provision of services to the community (42 C.F.R., Section 2.40). The net effect is to permit, but not require, the provider to give patients access to their own alcohol or drug abuse records.

Occasionally, there is mention of alcohol or drug abuse in a record of medical or surgical care. The law does not apply to these isolated portions of the record when the patient has not been evaluated or treated for the abuse program and that access should be permitted.

#### PURPOSE:

To uphold the confidentiality of health record information.

---

#### PROCEDURE:

- A. Upon receipt of an authorized written request for alcohol and drug abuse health records:
  1. Determine if the patient has or is currently receiving alcohol and drug abuse treatment by examining the diagnosis or treatment entries within the patient records.
  2. If such entries are found, indicate that the patient has received alcohol and/or drug treatment in the remarks section on the log sheet (See Attachment M)
  3. Notify the Medical Director promptly (first working day after receipt) of any request by a patient to inspect or receive copies of an alcohol and/or drug abuse record.
    - a. The patient submits a written authorization that meets the requirements of the federal alcohol and drug abuse regulations, naming himself as the recipient of the information; and
    - b. The responsible practitioner or other professional determines that such disclosure will not hurt the patient; and
    - c. The Program Director determines that disclosure will not damage the program.

If all these conditions are met, the Hospital may (but is not required to) release the record to the patient. The Health Information Services Department must be advised no later than the fourth working day if denial is recommended; otherwise access will be permitted. (use of a separate authorization form is required – see Attachment N).

4. If the Medical Director denies access, a record must be kept of the reason for denial and the individuals making that determination. Indicate the reason for the denial, the date the requestor was notified and the individual denying access in the log sheet (see Attachment M).
5. Notify the requesting patient/guardian that access is being denied in accordance with Federal and State regulations and keep a copy of the communication with the patient record (Exhibit M)

**B. ARCH CHARTS**

1. Follow policy and procedures for release of alcohol and drug abuse records.

Most recent review: 08/2008, 08/2009  
Revised: 08/10/2009  
Original adoption: 08/1986

DELETE INCLUDED IN 13.1

DELETE INCLUDED IN 13.1

## RELEASE OF INFORMATION

### HIV ANTIBODY TEST RESULTS:

#### POLICY:

California has stringent confidentiality restrictions on the release of the results of the HIV antibody test, requiring careful handling  
[California Health and Safety Code 199.1, et. Seq., revision effective January 1, 1989.]

#### PURPOSE:

1. To protect the patient's right to confidentiality in releasing such information. A patient's medical information should be disclosed outside the facility only to the extent necessary for the purpose for which release is authorized.

---

#### I. PROCEDURE:

- A. Record all inquiries either written or verbal on the correspondence log or other Miscellaneous Correspondence Log respectively.
- B. Check to verify if patient is or ever was hospitalized at LHH using:
  1. Patient Information System and/or
  2. Master Patient Index (MPI), Active and Inactive
- C. Check the consent form to be sure that the signature is valid and the consent is complete.  
**NOTE:** If HIV status is mentioned anywhere in the record, it must be specified on the authorization.
- D. If patient cannot be identified, return inquiry to sender with an explanation (see attached form #1 or 2). If consent is not complete, return asking for a proper one before record can be released. E. Place correspondence in file folder according to date received.
- F. If patient is on the unit, pick up chart, Xerox information requested and return chart to the nursing station as soon as possible.
- G. For discharge charts, pull from Health Information Services, xerox records requested and return chart(s) to proper location.
- H. Log in information released and date sent out.
- I. Place original correspondence in miscellaneous section of chart in front of records from other hospitals or other correspondence.  
**NOTE:** Correspondence must be handled within fifteen (15) days unless you have reason to hold it.

#### TELEPHONE INQUIRIES

1. Find out exactly what information caller wants.
2. Take name and telephone number.
3. Give only admission and discharge dates.
4. Call back with information.

## RELEASE OF INFORMATION

### RELEASE OF INFORMATION ON MINOR PATIENTS:

#### POLICY:

The law gives minors the right to consent to treatment and therefore the exclusive right to inspect or receive copies in two types of situations:

1. Where the minor has special legal status (i.e. as a self-sufficient or emancipated minor).
2. Where the condition being treated is special (e.g. the prevention or care of pregnancy, or the treatment of alcohol or drug abuse).

---

#### PURPOSE:

1. To uphold the confidentiality of health record information.

#### PROCEDURE:

##### I. Upon receipt of authorized written request of minor:

- A. Determine if the minor patient meets the above conditions by examining patient consent form and documentation related to legal status and medical diagnosis and treatment.
- B. Indicate results of review on the log sheet (see attachment M)
- C. Notify the Medical Director promptly (first working day after receipt) of any request by minor patient to inspect or receive copies of their medical records. The Medical Director will notify the Health Information Services Department no later than the fourth working day after receipt if he/she is requesting denial; otherwise access will be permitted.
- D. If the Medical Director or attending physician is unavailable to make such a determination, medical records staff will contact the requesting party and request an extension. In the event an extension is not granted, medical records staff will refer the request to an Administrator to make the determination.
- E. If the Medical Director denies access, a record must be kept of the reason for denial and the individuals mailing that determination. Indicate the reason for denial, the date the requestor was notified and the individual denying access in the log sheet (See Attachment M)
- F. Notify the requesting parent/guardian that access is being denied on the basis of either exception and keep a copy of the communication with the patient record (see Exhibit G)

##### II. Upon receipt of an authorized written request from a patient representative of a minor:

- A. Of only a portion of the record belongs to a category to which the minor has the right of inspection, that part should be removed before a parent or guardian is given access.
- B. Notify the Medical Director promptly (first working day after receipt) of any request by a patient representative of a minor to inspect or receive copies of the medical record. The Medical Director or attending physician will notify the Health Information Services Department no later than the fourth working day after receipt if he/she is requesting denial; otherwise access will be permitted.

C. Refer to steps 1D to 1F

Most recent review: 08/2008, 08/2009

Revised: 08/10/2009

Original adoption: 08/1986

P.1 of 1

DELETE INCLUDED IN 13.1

**MEDICAL RECORDS COMMITTEE REVIEW — THIS REVIEW HAS NOT  
BEEN DONE OVER 10 YEARS**

In Revision Process (May 2010)

**POLICY:**

A random selection of charts will be reviewed by the Medical Records Committee.

**PURPOSE:**

To insure that complete medical records are developed and retained for every patient/resident treated.

**PROCEDURE:**

**I. HEALTH INFORMATION DEPARTMENT**

- a. Records shall be reviewed for their timely completion, clinical pertinence and overall adequacy for use in patient care evaluation and medico-legal documentation.
- b. Reviewing members shall consist of representatives from: Medical Department, Nursing, Rehab Services, Social Services, Dietary, Activity Therapy, and Admissions and Eligibility.
- c. A random selection of eight (8) charts will be made available for the committee members to review.
- d. Review forms will be generated and placed in the medical record.

**II. REVIEWING COMMITTEE MEMBERS**

- a. Conducts retrospective reviews for adequacy and completeness of medical records according to each discipline's departmental standards and guidelines.
- b. Reports to the Medical Records Committee the results of the review and the corrective action taken on deficiencies.

**III. MEDICAL RECORDS COMMITTEE MEETING**

- a. Conducts retrospective reviews for adequacy and completeness of medical records according to each discipline's departmental standards and guidelines.
- b. Reports to the Medical Records Committee the results of the review and the corrective action taken on deficiencies.

**~~IV4. MEDICAL RECORDS COMMITTEE MEETING~~**

- a. ~~The documentation of the results of the review and the respective corrective action taken by each discipline will become part of the minutes in the meeting.~~
- b. ~~Copies of the minutes will be forwarded to the Medical-Executive Committee.~~

Most recent review: 08/2009

Revised: ~~2009/08/10/2009~~

Original adoption: ~~1986/0808/1986~~

DELETED



**MEDICAL STAFF ~~HIS NOT JUST TRACKING IF ADVANCE DIRECTIVE IS PRESENT OR NOT~~**

**ADVANCE DIRECTIVES:**

**POLICY:**

1. ~~LHH shall provide each patient/resident at the time of admission, information regarding Advance Directives.~~
2. ~~This hospital shall comply with California statutes and court decisions regarding Advance Directives.~~
3. ~~This hospital shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.~~

**PURPOSE:**

1. ~~To ensure that a patient's/resident's choice regarding Advance Directives is respected.~~
2. ~~To assure that resident wishes regarding treatment are followed, including right to accept or reject medical or surgical care.~~

**PROCEDURE:**

**I. ADMITTING**

- A. ~~Ask the resident or the resident's representative if there is an Advance Directive, living will or DPAHC.~~
- B. ~~Obtain a copy of any Advance Directive for both the admitting office file and for attachment to form #124 (Consent/Directives Summary Statement).~~
- C. ~~Complete the MDS section on Advance Directives as applicable.~~
- D. ~~Stamp Form #124 with addressograph, complete section I and attach to admitting record.~~
- E. ~~Enter notation on resident/admitting database stating if an Advance Directive is available and type.~~

- F. ~~For readmissions, attach a copy of any prior Advance Directive to the Form #124.~~
- G. ~~When a DPAHC is executed while the resident is a patient at LHH, Admitting will generate a revised form #124 for review by physician.~~

P.1 of 2

Laguna Honda Hospital & Rehabilitation Center

Policy Number: 15.01

Health Information Services Policy & Procedures

Revised: AUG 2009

H.

t.G.

## **II. RESPONSIBILITY: PHYSICIAN**

- A. Complete form #124 on admission and readmission.
- B. Document Advance Directives in chart and indicate on order sheet.
- C. If there are no Advance Directives, follow the Medical Staff Advance Directive Policy.
- D. When a resident transfers to another ward in the hospital, review and document Advance Directives at time of transfer.
- E. If condition on form #124 regarding inability of resident to make decisions is considered temporary, review form #124 every three months at MDS multidisciplinary rounds.

## **III. RESPONSIBILITY: NURSING**

- A. Check on the accuracy of the MDS form on admission and quarterly.
- B. Review Advance Directives with M.D. and chart the discussion.
- C. When resident is transferred to another facility, ensure that the Advance Directive currently in the chart is transferred with the resident.

## **IV. RESPONSIBILITY: HEALTH INFORMATION SERVICES**

- A. Review MDS form and verify Advance Directive documents indicated.
- B. If form #124 is not completed, send deficiency notice to M.D. and follow 7 day recheck procedure.
- C. Ensure that all Advance Directives are kept filed in the legal document section of each patient's/resident's clinical record. This will be checked on admission, readmission and transfer.
- E. Physician Order Processing will identify all Advance Directive notations on the order and enter information in A-Directive Section on printed order sheet.
- F. Ward Analysts will monitor for A-Directives executed after admission and alert Admissions & Eligibility.
- G. On request, HIS/Data Section will generate a printed report of all parts with Advance Directives.

Most recent review: 08/2008, 08/2009

Revised: 2009/08/10/2009

Original adoption: 1986/08

P.2 of 2

DELETED

## **CLINICAL PERTINENCE – NO REVIEW DONE**

### **POLICY:**

~~A random selection of charts will be reviewed by the Medical Records Committee.~~

### **PURPOSE:**

~~1. To insure that complete medical records are developed and retained for every patient treated.~~

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### **PROCEDURE:**

#### **I. HIS Department**

- A. ~~Records shall be reviewed for their timely completion, clinical pertinence and overall adequacy for use in patient care evaluation and medico-legal documentation.~~
- B. ~~Reviewing members shall consist of representatives from: Medical Department, Nursing, Rehab Services, Social Services, Nutrition Services, Activity Therapy, and Admissions and Eligibility, Health Information Services.~~
- C. ~~A random selection of eight (8) charts will be made available for the committee members to review.~~
- D. ~~Review forms will be generated and placed in the medical record.~~

#### **II. Reviewing Committee Members**

- A. ~~Conducts retrospective reviews for adequacy and completeness of medical records according to each discipline's departmental standards and guidelines.~~
- B. ~~Reports to the Medical Records Committee monthly, the results of the review and the corrective action taken on deficiencies.~~

#### **III. Medical Records Committee Meeting**

- A. ~~The documentation results of the review and the respective corrective action taken by each discipline will become part of the Medical Records Committee meeting.~~

~~Most recent review: 08/2009  
Revised: 08/10/2009  
Original adoption: 08/1986~~

DELETE

## NURSING EDUCATIONAL AFFILIATIONS (Student Placements)

### Policyies:

1. Laguna Honda Hospital (LHH) supports the clinical training and education of nursing professions, including Nursing Assistants, Unit Clerks, Home Health Aides, Paramedic Students, Licensed Vocational Nurses, Registered Nurses, Advanced Practice Nurses and those enrolled in doctoral programs.
2. Each clinical instructor will not exceed ten (10) students per clinical shift. Clinical instructor will provide supervision to all their students.
3. All nursing students or preceptees, whether pre-certification, pre-licensure, or in a post-licensure course of education must:
  - a. Be enrolled in an educational institution approved by the Board of Registered Nurses, and/or Board of Vocational Nursing and Psychiatric Technicians.
  - b. Be enrolled in an educational program that has a current contract with the Department of Public Health. The contract stipulates responsibilities of faculty and of LH staff consistent with legal and ethical standards of practice.
  - c. Adhere to the following procedures.
  - d.
  - e. C.
- ~~2.—All nursing students/preceptees, whether pre-certification, pre-licensure, or in a post-licensure course of education must:~~
  - a. ~~be enrolled in an educational institution approved by the Board of Registered Nurses, and/or Board of Vocational Nursing and Psychiatric Technicians,~~
  - b. ~~be enrolled in an educational program that has a current contract with the Department of Public Health. The contract stipulates responsibilities of faculty and of LH staff consistent with legal and ethical standards of practice,~~
  - c. ~~adhere to the following procedures.~~
  - d. ~~For pre-licensure students, administering medications and treatments require direct supervision by their nursing instructor to ensure resident/patient safety.~~
4. The clinicalnursing instructor must communicate all planned treatments and medications prior to implementation for approval of the Charge Nurse.
5. The clinicalnursing instructor ~~or faculty~~ will complete the *Clinical Instructor's Sign-in Sheet* in the Nursing Office each day that they are on-site with the students.
6. Nursing Education Department is responsible for monitoring affiliations agreements and following up on clinical or educational concerns that occur as a result of student placements, and will provide a regular update to the Chief Nursing Officer.
7. To avoid conflicts of interests, LH staff are not permitted to be paid employees of educational programs and to supervise students at LHH.

### Purpose:

1. To outline guidelines to ensure a safe and educationally sound clinical experience.
2. To clarify the roles and responsibilities of the school and the nursing staff of LHH.

**Procedures:**

A. One month prior to the practicum

1. ~~Faculty~~ The clinical instructor will send a request via email for student replacement completes a Request for Student Placement form and forwards it to the Affiliation Coordinator in the Nursing Education and Training Department. Recruitment and Retention Program.
2. ~~Faculty~~ The clinical instructor will electronically completes a Course/Clinical Learning Objectives form or sends a clinical syllabus to the Affiliation Coordinator.
3. ~~The clinical Faculty~~ instructor completes a *Clinical Instructor Information* form if one is not on file with the Affiliation Coordinator.
4. If the school has not had a recent affiliation with LHH (i.e. within the past school year), the Affiliation Coordinator will verify with the Contracts Office at (415) 554-2839 to determine if a current contract exists between the school and DPH.
5. ~~The clinical instructor Faculty~~ and the Affiliation Coordinator, in collaboration with the Nurse Manager, when applicable, determine the practicum dates, days, hours and the resident care units where students will be placed.
6. A written agreement is reached describing the clinical experience among the faculty, Affiliation Coordinator, and Nurse Manager. This agreement will specify the days and hours the student will be on the neighborhood, the skills the student will be practicing, services the students will be providing and programs the students will be developing. The written agreement will specify in writing the faculty's responsibility related to supervising pre-licensure students' administration of medication or treatments.
7. Students will receive orientation and SMART class prior to the first day of their clinical rotation.
8. The Affiliation Coordinator will send updates of orientation and new materials as needed to instructors. The instructors will submit an orientation attendance sheet and all required signed forms to Affiliation Coordinator on the first day of clinical rotation:
  - a. User Confidentiality, Security and Electronic Signature Agreement Form
  - b. Dependent Adult/Elder Abuse Prohibition and Reporting Requirement Form
  - c. Received a Copy of Resident's Bill of Rights Form
  - d. Emergency Information and Signature Form
9. For new clinical instructors, the Affiliation Coordinator will give an orientation to LHH. Schedule of orientation can be arranged with the coordinator via email or phone call.
7. Once request for clinical rotation is confirmed, the Affiliation Coordinator will electronically send required Student/Instructor Health Screening Verification Form, and Student/Instructor Roster/Clinical Schedule.
8. —
6. —
7. The Affiliation Coordinator arranges for an orientation to LHH.
- 9-10. —
- B. One week prior to practicum

~~Nursing's Affiliation Coordinator communicates with the involved Nurse Manager to reconfirm the placement is feasible given clinical issues or staffing changes on the neighborhood.~~



~~C.B.~~ Orientation to Clinical Instructor of Faculty and Students by LHH staff

- ~~1. Clinical Instructor orientation will be conducted by the Affiliation Coordinator. On the day of orientation the faculty or preceptee will provide LHH with a completed Student Roster/schedule form and a Student/Instructor Health Screening Verification form.~~
- ~~2. The following orientation content will be covered during the clinical instructor orientation: Each student /preceptee and instructor will complete LHH Health Information Services Confidentiality Statement and a Confidentiality Agreement: Use of DPH Records and Information Systems.~~
- ~~3.~~
- ~~4. The school faculty, students and preceptee shall sign a "signature card" which will be filed in the Medical Records Department. Faculty, students and preceptees may not document in the medical record if this card is not completed.~~

~~5.~~  
~~6.2.~~ Orientation will include:

- ~~a. History of Laguna Honda Hospital Information about the ribbon system and wristband color codes.~~
- ~~b. Descriptions of neighborhood and services provided by the hospital Information about resident rights, confidentiality, abuse and the role of a mandated reporter.~~
- ~~c. Resident Rights and Confidentiality Guidelines for Standard Precautions (or the school may provide documentation of classes/objectives demonstrating that the students have competency in the area of infection control).~~
- ~~d. Film on "it's Your Legal Duty" and Mandated Reporting Law Instruction in safe feeding techniques and associated risks of aspiration will be provided for any student or preceptee who may be involved in assisting with feeding.~~
- ~~e. Resident Color Codes: ID bands, ribbons, dot stickers, star sticker LHH staff will provide instruction for the safe operation of mechanical lifts for students whose clinical experience may include their use.~~
- ~~f. Specialized Feeding Plans~~
- ~~g. Fire Safety, Code Green, and Hand Hygiene~~
- ~~h. Therapeutic Communication~~
- ~~f.i. Facility tour by the Clinical Instructor Safe medication administration practices to prevent medication errors.~~

~~D.C.~~ Clinical Instructor Responsibilities Expectations of the School Faculty

- ~~1. The clinical instructor shall collaborate with the Charge Nurse or Nurse Manager to determine students' resident assignments.~~
- ~~4.2. At the start of the shift, the clinical instructor will complete the Student-Resident Assignment Clinical Rotation form. The form is given to the charge nurse or designee and will be filed in the CNA/PCA assignment binder. The clinical instructor will provide the Charge Nurse with the student assignment worksheet. A copy of the student assignment worksheet will be filed in the neighborhood. The ratio of student to faculty is not to exceed one instructor for ten students unless otherwise agreed upon in writing.~~
- ~~3. The clinical instructor will ensure that students receive hand-off report from the Charge Nurse or designee before providing care. The faculty will provide direct supervision for all students (i.e. will move among units where students are providing nursing care).~~
- ~~4. The clinical instructor will provide direct/line of sight supervision for each student during medication administration, and each student will be supervised during treatments by either the clinical instructor or the LHH licensed nurse. Students will **not** administer controlled substances.~~

The clinical instructor will co-sign for each medication administered, and the clinical instructor or LHH licensed nurse will co-sign for the treatment administered.

2.5. The clinical instructor will co-sign all documentation completed by student.

~~The clinical instructor will provide direct/line of sight supervision for each student during medication administration, and each student will be supervised during treatments by either the clinical instructor or the LHH licensed nurse. Students will **not** administer controlled substances. The clinical instructor will co-sign for each medication administered, and the clinical instructor or LHH licensed nurse will co-sign for the treatment administered. The faculty with the Charge Nurse or Nurse Manager will jointly determine all resident assignments. The clinical instructor will provide the Charge Nurse with the student assignment worksheet. A copy of the student assignment worksheet will be filed in the neighborhood.~~

~~The clinical instructor will co-sign all documentation completed by student. Faculty will ensure that students receive report from the Charge Nurse when they come on duty. When leaving the neighborhood, students report all relevant information to the Charge Nurse concerning the residents' care and status.~~

~~3.—~~

~~4.— Faculty will provide direct/line of sight supervision for each student for each medication and treatment administered. Students will **not** administer controlled drugs. The faculty will co-sign for each medication and treatment administered by each student.~~

~~5.— Faculty will co-sign all documentation completed by students.~~

~~6.— The school faculty will provide SMART training to all students and instructors and will be able to provide certification of completion on the first day of orientation.~~

~~7.— Faculty will confer with Affiliations Coordinator about nursing students having learning difficulties.~~

E.D. Expectations of Student Responsibilities

1. Each student must wear a visible school ID badge so that it can be easily identified.~~Each student shall wear a school ID badge so that it can be read easily. If the school does not provide ID badges, each student shall wear ID badge provided by LHH.~~

2. Each student must obtain a hand-off report from the Charge Nurse or designee before providing care. When leaving the neighborhood students will provide appropriate hand-off report to the Charge Nurse or designee, and clinical instructor.~~Each day that a student is present on the neighborhood, they shall enter their name, student status and school they are attending in the *Infection Control Notebook*.~~

3. Students needing to review medical records prior to clinical rotation must check in with the Charge Nurse and adhere to LHH policy on confidentiality (LHH 21-01 Medical Record Information: Confidentiality and Release).~~Each student will receive report from the Charge Nurse when they come on duty. Each student will report to the Charge Nurse, when leaving the neighborhood, all relevant information concerning the residents' care and status.~~

4. Seek guidance from their faculty member or Affiliations' Coordinator regarding activities and student role.

~~5.— If indicated, maintain a log detailing clinical hours that can be shared with the LHH staff.~~

E.F. Expectations of Affiliations Coordinator Responsibilities /Nursing Education Coordinator

~~29~~ September 0, 2015, Revised  
**Nursing Educational Affiliations**

*LHH Nursing Policies and Procedures*

1. ~~Ensure students completion of required forms for orientation described in C (1), C (2) and C (3).~~ Facilitate completion of forms described in C (1), C (2) and C (3).
2. ~~Provide required materials for student orientation prior to start of clinical rotation for the preceptee to be oriented to LHH.~~ Orient or arrange for the preceptee to be oriented to LHH.
3. ~~Maintain communication with the school affiliation.~~ Maintain communication with the school faculty.
4. Maintain communication with the school affiliation and report any problems related to the student.
- 4.5. ~~Keep records of students roster lists and neighborhood assignments assigned in the neighborhood including assigned information pertaining to instructors.~~ clinical instructors. Report any problems related to the preceptee to the school and when appropriate to LHH administrators.

**ATTACHMENT:**

Attachment 1: Student-Resident Assignment Clinical Rotation Form

**CROSS REFERENCE:**

LHHPP 84-01 Student Affiliation

LHH 21-01 Medical Record Information: Confidentiality and Release

Adopted: 1/2005

Revised: 10/2007; 09/27/2011; 09/08/2015

Reviewed: ~~09/27/2011~~ \_\_\_\_\_

Approved: ~~09/27/2011~~ \_\_\_\_\_



## LAGUNA HONDA HOSPITAL

### Student-Resident Assignment Clinical Rotation

Purpose: To be able to track student-resident assignment during their clinical rotation in the neighborhood.

School: \_\_\_\_\_

Date/Day of Clinical Rotation: \_\_\_\_\_

Neighborhood: \_\_\_\_\_

PRINT NAME	SIGNATURE	ROOM/BED NUMBER	RESIDENT INITIALS

Instructor: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\* Not part of Medical Record, this will be kept in CNA/PCA assignment binder.

## DOCUMENTATION OF RESIDENT CARE/STATUS by the LICENSED NURSE

### POLICY:

The Licensed Nurse (LN) ~~nursing~~ is responsible for recording ~~assessment in writing or electronically~~ ~~assessment~~ data ~~in writing or electronically~~, such as ~~personnel~~ the resident's health status, ~~development of a care plan based on identified needs~~, implementation or supervision of nursing interventions, and ~~evaluation and revision of~~ ~~updating R~~ resident ~~C~~are ~~P~~lan (RCP).

~~Nursing progress notes are to be concise and e, accurate. Documentation includes accounts of the resident's physical, emotional, spiritual, and recreational status, progression or regression in functional capabilities, or attainment of care plan goals and/or other changes in status. They are to reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.~~

~~1. NO LHH chart is to be sent to any other hospital. Photocopies of pertinent material will be sent with the resident, upon discharge, to another health facility~~

~~2. At least three months One year's worth of integrated progress notes will be kept on the unit neighborhood, with six months in the current chart, and six months on the nursing unit in the thinned drawer chart. Health Information System (HIS) technicians are responsible for to thin maintaining or add to the medical records.~~

### PURPOSE:

To communicate relevant information regarding assessment, interventions, and outcomes to ~~primary Resident Care Team (RCT) providers~~ to promote continuity and quality care for our residents.

~~1. To maintain a concise, accurate, confidential, legal document.~~

### BACKGROUND:

Documentation of resident care includes the resident's physical, emotional, spiritual, recreational status, functional capabilities, attainment of care plan goals and/or other changes in status and reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.

### PROCEDURE:

A. Refer to Appendix 1 Obtaining Nursing Forms, Medical Records and Chart Order.

B. Refer to LHHPP File: 21-05 Medical Record Documentation.

C. Frequency of Nursing Documentation

Documentation frequency varies as the resident's condition changes. The licensed nurse is responsible for ensuring that documentation in the progress notes reflecting assessment, planning,

interventions, outcomes, and evaluation are concise, accurate, and completed in a timely manner. Written documentation must be legible with licensed nurse name and title.

1. Pavilion Mezzanine Acute

Document as warranted by patient condition with a minimum of once per shift. Documentation includes assessment data, interventions implemented, and evaluation of patient's response to interventions.

2. Skilled Nursing Neighborhoods

a. Admissions, relocations, and post procedures – document a minimum of once per shift for at least 72 hours until condition is stable and resident has made the adjustment to the new environment. Weekly summaries are completed for at least a month and may be extended based on the resident's condition.

b. Medicare designation – Document a daily note at minimum, for the duration of coverage as indicated by Medicare sticker on the spine of the chart. Nursing documentation will specifically describe aspects of skilled nursing care designated as the focus of coverage in addition to routine physical assessment data. When no longer covered by Medicare, progress to monthly documentation schedule.

c. Unanticipated Change in resident condition or potential/actual decline – Document a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change. Then document daily until condition stabilizes or resolves. Some examples of changes in resident condition may include changes but not limited to, change in cognitive function or unusual behavior, abnormal vital signs, meal intake of less than 50%, infectious processes requiring antibiotics, abnormal bleeding, loss of functional ability, new incontinence, and exacerbation of a chronic condition.

d. Pavilion Mezzanine SNF – Document a minimum of once weekly for duration of rehabilitation. Documentation should reflect detailed description of the outcome of interventions, with an emphasis on degree of independence, resident education, and progress towards discharge planning goals.

e. Long Term SNF residents - Comprehensive monthly summaries will be documented for all residents. This summary is an evaluation of the resident's response to care provided. Data collection for the monthly summary includes physical assessment, review of the care plan, Daily Nursing Care Record (DNCR), progress notes (in medical record, hard chart and electronic health record), vital signs, height and weight, medication and treatment records. If the resident has an unanticipated change in condition, frequency of documentation will increase as often as condition warrants and until stabilized.

f. Discharge – refer to NPP C 1.3 Discharge to Acute and LHHPP 20-04 Discharge Planning.

g. The Care Area Assessment (CAA) - documentation will be done after completion of a comprehensive MDS comprehensive MDS assessment and care planning.

D. Documentation other than Progress Notes

1. Admission documentation (Refer to Admission-Relocation-Discharge Procedures).

## Documentation of Resident

File: C 3.0 February 14, 2014 May 28, 2015 September 8 July

17 no 5, 2015, Revised

Status/Documentation of Resident Care by the Licensed Nurse

LHH Nursing Policies and Procedures

2. The Assessment section of the medical record contains the Nursing Admission Assessment and other nursing assessment forms. Please refer to table of chart orders for location of other nursing forms (Appendix I).
3. Licensed nurse documentation includes completion of specific assessment and evaluation tools. See Appendix 1 for Nursing Assessment Forms.
4. Medication and Treatment Administration Record Documentation
  - a. Documentation on medication record sheets includes name of drug, dosage, route, time and site for parenteral drugs, frequency and nurse's initials.
  - b. Documentation on treatment record sheets includes the time, the treatment as ordered, pertinent observations and nurse's initials.
  - c. When PRN medications or treatments are administered, the reason and result of intervention are documented on the reverse side of the page.
  - d. Initials are identified by the nurse signing initials and full name printed legibly in "Initial" and "Signature" box.
  - e. Physician's orders, medication and treatment administration forms used by nursing must be reviewed for accuracy before being filed into the medical record. This procedure may be delegated to a licensed nurse on any shift.

~~Physician's orders, medication and treatment administration forms used by nursing must be reviewed for accuracy before being filed into the medical record. This procedure may be delegated to a licensed nurse on any shift.~~

5. Daily Nursing Care Record (DNCR)
  - a. Licensed Nurse is responsible for individualizing DNCR with resident specific interventions (e.g. restorative interventions or assistance during meals).
  - b. Licensed Nurse will document in the DNCR if the LN is assigned to provides direct assistance with resident's ADL.
  - c. Refer to NPP C 3.2 Documentation of Resident Care by Nursing Assistant.
  - d. Licensed Nurses are responsible for reviewing the documentation on the DNCR to ensure that care is provided as per care plan.
6. Medication orders, vital signs, height, weight, labs, immunization, allergies, and point of care testing are documented electronically.

### A.E. See Appendix 2 for Charting/Documentation/Reporting Expectations A. (Equipment)

1. ~~Obtain blank chart forms from neighborhood unit supply or commissary. See Appendix I for the order of chart forms.~~
2. \_\_\_\_\_
3. ~~Call HIS one day in advance for chart requests.~~
4. \_\_\_\_\_

## Documentation of Resident

File: C 3.0 February 14, 2014 May 28, 2015 September 8 July

17 no 5, 2015, Revised

Status/Documentation of Resident Care by the Licensed Nurse

LHH Nursing Policies and Procedures

5. Delivery schedule is from 9:00 Aa.Mm. to 4:00 Pp.Mm., Monday through Friday, except holidays.

~~Requests for same day deliveries of closed medical records are accepted when residents are readmitted, or when needed for a unit or clinic physician's review. HIS requests notification as early as possible in the day, preferably before 8:00 A.M. Be sure to specify when a chart is requested for readmission.~~

6.

~~All charts obtained from HIS are to be returned within 72 hours.~~

7.

8. ~~All residents discharged within house, home or to outside facilities must have their records forwarded to HIS the day of discharge.~~

9.

### **B. (Flagging the Chart on the Spine)**

1. Flag chart according to color code:

- ~~a. RED New order to be noted~~
- ~~b. YELLOW Lab work~~
- ~~c. GREEN Clinical appointment~~
- ~~d. BLACK Neutral~~

~~Charting frequency sticker. Sticker may be yellow or another color with due dates for weekly and monthly summaries identified.~~

5. ~~LHH NP&P manuals are located in the following areas: Nursing Office, Nursing Education, Quality Management and Chief Nursing Officer.~~

### **C. Frequency of Nursing Documentation in Resident Care Team (RCT) Progress Notes**

~~Documentation frequency varies as the resident's condition changes. The charge nurse is responsible for ensuring that documentation is completed in a timely manner, determines the frequency of charting based on professional nursing judgment. The charge nurse will label the spine of each chart to indicate the minimum charting frequency for residents who require nursing notes more often than monthly.~~

1. Pavilion Mezzanine Acute Acute Rehab and Acute Medical Units

~~Chart Document as often as warranted by resident patient condition with a minimum of once per shift, as long as the resident is on the acute neighborhood ward. Include specifics of interventions related to acute condition as well as assessment of overall condition. Documentation includes assessment data, interventions implemented, and evaluation of patient's response to interventions.~~

2. Skilled Nursing Neighborhoods Skilled Nursing Units

~~Admissions, relocations, and post-surgical procedures document a minimum of once per shift for at least 72 hours until condition is stable and resident has made the adjustment to the new environment. Weekly summaries are indicated completed for at least a month and may be extended based on the resident's condition. The charge nurse is to use professional judgment to determine the need to continue weekly charting for residents with a newly diagnosed condition or for those with complex skilled nursing needs who are considered at increased risk for complications, for example: intravenous therapy, pressure ulcers, wounds, enteral tube feedings, respiratory problems, anticoagulants, or psychoactive medications.~~



- ~~— Medicare designation — Document a minimum daily note at minimum, for the duration of coverage as indicated by Medicare sticker on the spine of the chart. Notes Nursing documentation will are to specifically describe aspects of skilled nursing care designated as the focus of coverage. When no longer covered by Medicare, progress to monthly documentation schedule.~~
  
- ~~Critical residents – a minimum of once per shift or more often as warranted by the resident's condition when resident's medical condition is unstable and there is an immediate threat to life. When condition is stable, progress to monthly notes.~~
  
- a. ~~Change in resident condition — Document a minimum of once per shift for 72 hours and as often as clinically indicated needed depending on the nature of the change, and at minimum of once per shift for 72 hours; tThen document daily until condition stabilizes or resolves. Clinical knowledge and familiarity with resident will help detect significant symptoms or behaviors that may indicate the onset of a change from baseline condition. Examples of changes in resident condition may include This applies to mental, behavioral, and emotional, as well as physical changes, for example: impairment changes in cognitive function or unusual behavior, abnormal variation in vital signs, infectious processes requiring antibiotics, abnormal bleeding, unusual behavior, and loss of functional ability in an extremity, and exacerbation of a chronic condition, or uncontrolled diabetes.~~
  
- b. ~~Admissions, relocations, and post-surgical procedures – minimum of once per shift for at least 72 hours until condition is stable and resident has made the adjustment to the new environment. Weekly summaries are indicated for at least a month. The charge nurse is to use professional judgment to determine the need to continue weekly charting for residents with a newly diagnosed condition or for those with complex skilled nursing needs who are considered at increased risk for complications, for example: intravenous therapy, pressure ulcers, wounds, enteral tube feedings, respiratory problems, anticoagulants, or psychoactive medications.~~
  
- c. ~~Medicare designation – minimum daily note for the duration of coverage as indicated by Medicare sticker on the spine of the chart. Notes are to specifically describe aspects of skilled nursing care designated as the focus of coverage. When no longer covered by Medicare, progress to monthly documentation schedule.~~
  
- ~~— Pavilion Mezzanine Skilled Nursing Facility (SNF) Rehab — Document a minimum of once weekly for duration of rehabilitation. Documentation should reflect detailed description of the outcome of interventions, with emphasis on with an emphasis on degree of independence, resident teaching education, and progress towards discharge planning goals, and degree of independence in activities of daily living.~~
  
- ~~— Long Term SNF residents - when the resident is responding to treatment interventions, Comprehensive monthly summaries will be written documented for all residents. This summary is an professional evaluation of the resident's, and his/her response to care provided. Data collection for the monthly summary includes physical assessment, review of the care plan, Daily Nursing Care Record (DNCR) ADL Notes, nursing, physician and other interdisciplinary progress notes (in hard chart and electronic health record), vital signs, height and weight, and graphic, medication and treatment records. If the resident has a change in condition, frequency of documentation will be done increase as often as condition warrants and until stabilized.~~

~~— Discharge — refer to NPP C 1.3 Discharge Procedure and LHHPP 20-04 Discharge Planning. refer to NPP Discharge Procedure~~

- ~~d. The A Care Area Assessment (CAA) Resident Assessment Protocol (RAP) documentation note will be done written after the completion of a comprehensive full MDS assessment for those areas in which nursing has primary responsibility.~~

#### ~~D. Documentation other than Resident Care Team Interdisciplinary Team (RCT) Progress Notes~~

- ~~1. Admission documentation (Refer to Admission-Relocation-Discharge Procedures).~~

- ~~2. The Assessment section of the medical record contains the Nursing Admission Assessment and other nursing assessment forms. Please refer to table of chart orders for location of other nursing forms (Appendix I).~~

~~— Licensed nurse documentation includes completion of specific assessment and evaluation tools (e.g. Behavior Monitoring Record (BMR), Wound Assessment Record (WAR), Post-Fall Assessment).~~

- ~~3. Medication and Treatment Administration Record Documentation.~~

~~— Charting Documentation on medication record sheets includes name of drug, dosage, route, time and site for parenteral drugs, frequency and nurse's initials, and signature.~~

~~— Charting Documentation on treatment record sheets includes the time, the treatment as ordered, pertinent observations and, nurse's initials, and signature.~~

~~— When PRN medications or treatments are given administered, the reason and result of intervention are charted documented on the reverse side of the page and must have reason given and resulting effect.~~

~~— Initials are identified by the nurse signing initials and full name printed legibly in "Initial" and "Signature" box at end of page.~~

- ~~a. Word processed pPhysician's orders, medication and treatment administration forms used by nursing service must be reviewed for accuracy before being incorporated filed into the medical record. This procedure may be delegated to a licensed registered nurse on any shift.~~

- ~~4. Daily Nursing Care Record (DNCR).~~

~~— Licensed Nurse is responsible for individualizing DNCR with resident specific interventions (e.g. restorative interventions or assistance during meals).~~

~~— Documentation of the resident's daily activities is to be written each shift on the DNCR Notes form by the CNA or PCA, or licensed nurse responsible for giving the care. When a change in the resident's condition is observed, the charge nurse is to be notified immediately and a narrative note is to be written in the "Supplemental Notes" section including name of the nurse notified. For the coding of the DNCR see NPP C 3.2.~~

~~a. C 3.2.~~

~~b. —~~

- ~~a. \*\* Licensed Nurses are responsible for reviewing the documentation on the DNCR done by CNAs or PCAs to ensure that care is provided as per care plan accurate documentation.~~

## Documentation of Resident

File: C 3.0 ~~February 14, 2014~~ ~~May 28, 2015~~ ~~September 8~~ ~~July~~

~~17~~ ~~no 5, 2015~~, Revised

~~Status/Documentation of Resident Care by the Licensed Nurse~~

*LHH Nursing Policies and Procedures*

- ~~5. Interdisciplinary Resident Care Team (RCT) Team conferences are documented on the form provided by Medical Records.~~
- ~~6. Minimum Data Set (MDS) assessment and documentation are to be initiated upon admission and completed as the schedule requires. (Refer to MDS Manual).~~
- ~~7. Invision LCR Vital signs, height, weight, labs, and point of care are documented electronically.~~
- ~~8.~~

### APPENDICES:

- ~~Appendix 1: Obtaining Nursing Forms, Medical Records, and Chart Order~~
- ~~Appendix 2: Charting/Documentation/Reporting Expectations~~
- ~~† Chart Order of Nursing Forms~~

### REFERENCES:

Health Information Services Universal Chart Order  
RAI/MDS Manual

### CROSS REFERENCES:

NPP B 5.0 Color Codes  
NPP C 1.0 Admission and Readmission Procedure  
NPP C 1.2 Relocation Procedure  
NPP C 1.3 Discharge ~~Procedure to Acute~~  
~~NPP C 3.1 Guidelines for Documentation of Resident Care by the Licensed Nurse~~  
NPP C 3.2 Documentation of Resident Care by ~~Certified Nurse Assistants and Patient Care~~  
~~Assistants~~  
NPP C 4.0 Notification and Documentation of a Change in Resident Status  
~~NPP D 8.0 Post-Mortem Care~~  
  
[LHHPP 20-04 Discharge Planning](#)  
[LHHPP 21-05 Medical Record Documentation](#)

Adopted: 8/2002

Revised: 9/2009; 06/16/2015; 09/08/2015

Reviewed: \_\_\_\_\_

**Documentation of Resident**

File: C 3.0 ~~February 14, 2014~~ ~~May 28, 2015~~ ~~September 8~~ ~~July~~

~~17~~ ~~no 5, 2015~~, Revised

**Status/Documentation of Resident Care by the Licensed Nurse**

*LHH Nursing Policies and Procedures*

~~☐ Reviewed by Lisa and no revision recommended at this time.~~

Approved: \_\_\_\_\_

For Ghe use only:

Date sent to Policy Reviewer **01/28/14**

Date received from Policy Reviewer \_\_\_\_\_

Date reviewed by NEC \_\_\_\_\_

Date approved by NEC \_\_\_\_\_

Date routed to MEC \_\_\_\_\_

Date emailed to Karina \_\_\_\_\_

**APPENDIX I**

**Obtaining Nursing Documentation Forms, Medical Records, and Chart Order**

~~— Obtain blank chart forms from neighborhood supply or commissary.~~

~~— Call HIS one day in advance for chart requests.~~

~~— New and closed medical records are delivered from 9:00 A.M. to 4:00 P.M., Monday through Friday, except holidays.~~

~~— Requests for same day deliveries of closed medical records are accepted when residents are readmitted, or when needed for a unit or clinic physician's review. HIS requests notification as early as possible in the day, preferably before 8:00 A.M. Be sure to specify when a chart is requested for readmission.~~

**Documentation of Resident**

File: C 3.0 ~~February 14, 2014~~ ~~May 28, 2015~~ ~~September 8 July~~

~~17~~ ~~no 5, 2015~~, Revised

**Status/Documentation of Resident Care by the Licensed Nurse**

*LHH Nursing Policies and Procedures*

- ~~— All charts obtained from HIS are to be returned within 72 hours.~~
- ~~— All residents discharged within house, home or to outside facilities must have their records forwarded to HIS the day of discharge.~~
- ~~— Nursing forms chart order:~~

<u>Progress Notes Section</u> <ul style="list-style-type: none"><li><del>— Integrated Progress Notes</del></li><li><del>— RCT Note Sticker</del></li><li><del>— Focused Progress Notes</del></li><li><del>— Nursing Weekly/Summary</del></li></ul>
<u>Assessment Section</u> <ul style="list-style-type: none"><li><del>— Nursing Admission Assessments</del></li><li><del>— Resident Comprehensive Pain Assessment</del></li><li><del>— Nursing Assessment for Behavioral Risk</del></li><li><del>— Pressure Ulcer Risk Initial Post-Admission</del></li><li><del>— Wound Assessment Records</del></li><li><del>— On-going Pressure Ulcer Risk</del></li><li><del>— Continence Assessment</del></li><li><del>— Post-Fall Assessment</del></li><li><del>— Self Administration of Medication: RGT Assessment</del></li><li><del>— Safe Smoking Assessment</del></li></ul>
<u>MDS Section</u> <ul style="list-style-type: none"><li><del>— MDS Admission Assessment</del></li><li><del>— MDS Face Sheet Information</del></li><li><del>— MDS Discharge Tracking Form</del></li><li><del>— MDS Correction Request Form</del></li><li><del>— RCT Meeting Note</del></li></ul>
<u>Graphic Section</u> <ul style="list-style-type: none"><li><del>— Weight Record</del></li><li><del>— Diabetic Record</del></li><li><del>— Neurological Assessment Record</del></li><li><del>— Graphic Chart</del></li><li><del>— Pain Intensity Graphic Record</del></li><li><del>— Behavioral Summary Sheets</del></li></ul>
<u>ADL Section</u> <ul style="list-style-type: none"><li><del>— DNCR</del></li></ul>
<u>Medication/Treatment Section</u> <ul style="list-style-type: none"><li><del>— Medication Administration Record</del></li><li><del>— I.V. Flow Sheet</del></li><li><del>— CAPD Flow Sheet</del></li><li><del>— Treatment Administration Record</del></li></ul>

**~~CHART ORDER for NURSING FORMS~~**

**~~Chart Order of Nursing Forms~~**

<b>PROGRESS NOTES SECTION</b>
1. <del>INTEGRATED PROGRESS NOTES</del>
2. <del>IDT NOTE STICKER</del>
3. <del>FOCUSED PROGRESS NOTES</del>
4. <del>NURSING WEEKLY/MONTHLY SUMMARY</del>
<b>ASSESSMENT SECTION</b>
1. <del>NURSING ADMISSION ASSESSMENTS</del>
2. <del>RESIDENT COMPREHENSIVE PAIN ASSESSMENT</del>
3. <del>NURSING ASSESSMENT FOR BEHAVIOR RISK</del>
4. <del>PRESSURE ULCER RISK INITIAL POST-ASSESSMENT</del>
5. <del>WOUND ASSESSMENT RECORD</del>
6. <del>ONGOING PRESSURE ULCER RISK</del>
7. <del>CONTINENCE ASSESSMENT</del>
8. <del>POST FALL ASSESSMENT</del>
9. <del>SELF-ADMINISTRATION OF MEDICATION: IDT ASSESSMENT</del>
10. <del>SAFE SMOKING ASSESSMENT</del>
<b>MDS SECTION</b>
1. <del>MDS ADMISSION ASSESSMENT</del>
2. <del>MDS FACE SHEET INFORMATION</del>
3. <del>MDS DISCHARGE TRACKING FORM</del>
4. <del>MDS CORRECTION REQUEST FORM</del>
5. <del>IDT MEETING NOTE</del>
<b>GRAPHICS SECTION</b>
1. <del>WEIGHT RECORD</del>
2. <del>DIABETIC RECORD</del>
3. <del>NEUROLOGICAL ASSESSMENT RECORD</del>
4. <del>GRAPHIC CHART</del>
5. <del>PAIN INTENSITY GRAPHIC RECORD</del>
6. <del>BEHAVIORAL SUMMARY SHEETS</del>
<b>ADL SECTION</b>
1. <del>DAILY NURSING CARE RECORD</del>
<b>MEDICATION/TREATMENT SECTION</b>
1. <del>MEDICATION RECORD</del>
2. <del>IV FLOW SHEET</del>
3. <del>CAPD FLOW SHEET</del>
4. <del>TREATMENT RECORD</del>

## APPENDIX 1: Obtaining Nursing Documentation Forms, Medical Records, and Chart Order

↓

### Obtaining Nursing Documentation Forms, Medical Records, and Chart Order

1. Obtain blank chart forms from neighborhood supply or commissary.
2. Call HIS one day in advance for chart requests.
3. New and closed medical records are delivered from 9:00 A.M. to 4:00 P.M., Monday through Friday, except holidays.
4. Requests for same day deliveries of closed medical records are accepted when residents are readmitted, or when needed for a unit or clinic physician's review. HIS requests notification as early as possible in the day, preferably before 8:00 A.M. Be sure to specify when a chart is requested for readmission.
5. All charts obtained from HIS are to be returned within 72 hours.
6. All residents discharged within house, home or to outside facilities must have their records forwarded to HIS the day of discharge.
7. Nursing forms chart order:

Progress Notes Section 1. Integrated Progress Notes 2. <del>RCT Note Sticker</del> 3. <u>2</u> Focused Progress Notes 4. <u>3</u> Nursing Weekly/ <u>Monthly</u> Summary
Assessment Section 1. Nursing Admission Assessments 2. Resident Comprehensive Pain Assessment 3. Nursing Assessment for Behavioral Risk 4. Pressure Ulcer Risk Initial Post-Admission 5. Wound Assessment Records ( <u>W.A.R.</u> ) 6. On-going Pressure Ulcer Risk 7. Continence Assessment 8. Post-Fall Assessment 9. Self-Administration of Medication: RCT Assessment 10. <u>Neurological Assessment Section</u> 10. <u>11</u> . <u>Behavioral Monitoring Record</u> <del>Safe Smoking Assessment</del>
MDS Section 1. MDS Admission Assessment 2. MDS Face Sheet Information 3. MDS Discharge Tracking Form 4. MDS Correction Request Form 5. RCT Meeting Note
<u>Graphic Section</u>

<ul style="list-style-type: none"><li>1. <del>Weight Record</del></li><li>2. <del>Diabetic Record</del></li><li>3. <del>Neurological Assessment Record</del></li><li>4. <del>Graphic Chart</del></li><li>5. <del>Pain Intensity Graphic Record</del></li><li>6. <del>Behavioral Summary Sheets</del></li></ul>
<p><u>DNCR ADL</u> Section</p> <ul style="list-style-type: none"><li>1. DNCR</li></ul>
<p>Medication/Treatment Section</p> <ul style="list-style-type: none"><li>1. Medication Administration Record</li><li>2. <del>I.V. Flow Sheet</del></li><li>3.2. <u>CAPD Flow Sheet</u></li><li>3. Treatment Administration Record</li><li>4. <u>Behavioral Summary Sheet</u></li></ul>



<b>PROGRESS NOTES SECTION</b>
1. <del>INTEGRATED PROGRESS NOTES</del>
2. <del>IDT NOTE STICKER</del>
3. <del>FOCUSED PROGRESS NOTES</del>
4. <del>NURSING WEEKLY/MONTHLY SUMMARY</del>
<b>ASSESSMENT SECTION</b>
1. <del>NURSING ADMISSION ASSESSMENTS</del>
2. <del>RESIDENT COMPREHENSIVE PAIN ASSESSMENT</del>
3. <del>NURSING ASSESSMENT FOR BEHAVIOR RISK</del>
4. <del>PRESSURE ULCER RISK INITIAL POST-ASSESSMENT</del>
5. <del>WOUND ASSESSMENT RECORD</del>
6. <del>ONGOING PRESSURE ULCER RISK</del>
7. <del>CONTINENCE ASSESSMENT</del>
8. <del>POST FALL ASSESSMENT</del>
9. <del>SELF-ADMINISTRATION OF MEDICATION: IDT ASSESSMENT</del>
10. <del>SAFE SMOKING ASSESSMENT</del>
<b>MDS SECTION</b>
1. <del>MDS ADMISSION ASSESSMENT</del>
2. <del>MDS FACE SHEET INFORMATION</del>
3. <del>MDS DISCHARGE TRACKING FORM</del>
4. <del>MDS CORRECTION REQUEST FORM</del>
5. <del>IDT MEETING NOTE</del>
<b>GRAPHICS SECTION</b>
1. <del>WEIGHT RECORD</del>
2. <del>DIABETIC RECORD</del>
3. <del>NEUROLOGICAL ASSESSMENT RECORD</del>
4. <del>GRAPHIC CHART</del>
5. <del>PAIN INTENSITY GRAPHIC RECORD</del>
6. <del>BEHAVIORAL SUMMARY SHEETS</del>
<b>ADL SECTION</b>
1. <del>DAILY NURSING CARE RECORD</del>
<b>MEDICATION/TREATMENT SECTION</b>
1. <del>MEDICATION RECORD</del>
2. <del>IV FLOW SHEET</del>
3. <del>CAPD FLOW SHEET</del>
4. <del>TREATMENT RECORD</del>

## ~~GUIDELINES FOR DOCUMENTATION OF RESIDENT CARE by the~~ ~~LICENSED NURSE~~ Appendix 2: Charting/Documentation/Reporting Expectations

### **POLICY:**

- ~~1. The licensed nursing personnel who assess the resident's health status, and administer or supervise nursing care are responsible for writing progress notes and updating nursing interventions in the resident care plan.~~
- ~~2. Nursing progress notes are to be concise, accurate accounts of the resident's physical, emotional, spiritual and recreational status, progression or regression in functional capabilities or attainment of care plan goals and other changes in status. They are to reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.~~
- ~~3. NO LHH chart is to be sent to any other hospital. Photocopies of pertinent material will be sent with the resident, upon discharge, to another health facility.~~

### **PURPOSE:**

- ~~1. To guide Licensed Nurses in communicating relevant information regarding assessment, interventions, and outcomes to primary care providers to promote continuity and quality care for our residents.~~
- ~~2. To maintain concise and accurate documentation.~~

### **PROCEDURE:**

#### **A. Equipment**

~~Focused Progress Note Stamp and stamp pad~~

#### **B.A. General Charting/Charting Documentation/Reporting Expectations Guidelines**

- ~~1. Write or print legibly on the proper forms in black ink, using military time ~~the 24-hour clock~~.~~
- ~~2. Imprint resident name and information on each page of the medical record using the addressograph ~~machine~~.~~
- ~~3. Each entry is to be signed, at the time and dated and includes the ~~it is written with the~~ nurse's first initial or first name, surname and license designation.~~
- ~~4. Chart in chronological order and DO NOT leave blank spaces between entries. Fill in blank spaces by drawing a line to the end of each entry.~~
- ~~5. Late Entry: When an entry has been omitted and others have documented or recorded in the Progress Notes, a late entry may be written. Late notes will be written after the last charted progress note. Do not insert the late entry where it was omitted. Write the current date, time and~~

**Guidelines Charting for Documentation/Reporting of**

File: C 3.1 ~~September, 2009~~ ~~September 8~~ ~~July 176, 2015~~, Revised ~~New~~  
**Expectations – Appendix 2 Resident Care by the Licensed Nurse**

LHH Nursing Policies and Procedures

the words "Late Entry" for the original date and time of the omission and the content of the late entry.

Example: 6/12/15 1400 Late Entry from 06/11/15 1000

- ~~3.6.~~ Restrict abbreviations to those listed on the approved LHH Abbreviations list.
- 4.7. **Errors** are to be corrected by drawing a single line through the error, printing "error" over the lined-out area and printing initials. No erasures or whiteout are to be made on any page of the medical record.
- ~~5.~~ ~~Don't generalize or use vague terms. Be specific in describing observations, physical findings and/or behavior. Give examples. Do not use the chart to accuse, blame or draw unfounded conclusions. Prejudging or labeling can impair resident care and caregiver integrity.~~
- ~~6.8.~~ Notify Admissions and Eligibility for when changes in the names, addresses, responsibility responsible parties and/or phone numbers shown on the face sheet become known.
- ~~7.9.~~ The following original forms are to remain in the active medical record. When a discharged resident is readmitted these particular forms are transferred into the new chart.
  - ~~a.~~ Chronological Record of Admission-Transfer/Relocation-Discharge
  - ~~b.~~ Tonometry and Immunization Record
  - ~~c.a.~~ Ophthalmologist and Optometrist progress notes
  - ~~d.b.~~ Advanced Directives Progress Notes, MR 702

**C. Charting Documentation Guidelines Tips for Completion of Resident Care Team (RCT) Interdisciplinary Progress Notes Nursing Forms**

- ~~1.~~ Licensed nurses are to use basic charting guidelines when writing progress notes.
  - ~~— Each nursing entry should include is to be identified by complete date and for month, day, year, and time, of the hour and minutes. Include Include signature with initial or first name, surname and title. When a Weekly or Monthly Summary is written, label entry as such.~~
- ~~2.1.~~ When a Weekly or Monthly Summary is written, check the appropriate box
- ~~3.2.~~ Identify and describe a Documentation in the Weekly or Monthly Summary should will include review of the care plan goal the problem, the interventions, used to resolve it and the resident's response (outcome outcomes, response to interventions, and revision of interventions when warranted and resident's response). Indicate progression or regression of resident's condition and attainment of the goals stated on the care plan.
- ~~4.~~ Chart in chronological order and DO NOT leave blank spaces between entries. Write on every line and fill in blank spaces by drawing a line to the end of each entry.
- ~~5.~~ **Late Entry:** When an entry has been omitted and others have charted in the Resident Care Team (RCT) Interdisciplinary Progress Notes, a late entry may be written, if the nurse can clearly recall pertinent information. Late notes will be written after the last charted progress note. There is to be Do not attempt to insert the late entry where it was omitted. Write the current date, time and the words "Late Entry" for the original date and time of the omission and the content of the late entry.

**Guidelines Charting for / Documentation / Reporting of**

File: C 3.1 ~~September, 2009~~ ~~September 8~~ ~~July~~ ~~176, 2015~~, Revised ~~New~~  
**Expectations – Appendix 2 Resident Care by the Licensed Nurse**

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- ~~6. Ensure accuracy and continuity. Record important information about problems or high-risk situations as soon as possible after they occur.~~
- ~~7. Progress notes are to include notifications to physician, stating the date, time, name of physician, what the physician was notified about, the physician's response, what orders were carried out and the resident response to interventions.~~
- ~~8.3. Consistent documentation is required when a resident refuses treatment or nursing care, for discussions about consequences to health and safety, and negotiations with resident to solve differences.~~
- ~~9.4. The **Focused Progress Note** (FPN) ~~will be initiated~~ ~~initiate~~ when a resident condition or incident requiring focused assessment, immediate action, and follow-up is identified. It includes an accurate description of the event as it relates to the resident. Nursing is responsible for completing a description of the situation, performing and documenting an initial assessment, initiating notifications and immediate actions, modifying the care plan and facilitating prompt follow up. The FPN ~~stamp~~ ~~is titled in the~~ ~~imprinted in the~~ Resident Care Team (RCT) ~~Interdisciplinary Progress Notes~~ ~~with~~. ~~It is dated, timed and signature ed, as are all progress notes.~~~~
- ~~10. When a resident reports a concern about hospital staff, lack of treatment, verbal or physical mistreatment, the charge nurse is to investigate immediately, notify the nursing supervisor, document the resident's statements and action taken in the nursing progress notes and send a Confidential Report of Unusual Occurrence form to the quality assurance mailbox.~~
- ~~11. Summaries may be written on any shift with input from the resident, family and nursing staff on each shift.~~

**Weekly Summary**

~~Weekly summaries will relate to the care plan and address all active problems, resident responses to care, and progress or lack of progress in reaching goals. Use form MR 352 and check weekly summary box.~~

**12.5. Weekly / Monthly Summary (MR 352)**

- a. In progress notes the nurse will address each active care plan problem, progress or lack of it in reaching goals and any change in status from previous ~~week or~~ month.
- b. To ~~be certain~~ ~~ensure~~ the RCP is up to date ~~with new problems~~, the nurse will examine resident for physical findings related to their identified problem areas and speak with the resident about their progress, concerns, and goals.
- c. The nurse will review the Resident Care Plan as the essential aspect of data collection for the ~~monthly~~ summary. Other sources of written ~~and electronic~~ information ~~that are pertinent (e.g., weight, V/S, DNCR, and other assessment forms).~~ ~~include the graphic record, weight sheet, physician or other interdisciplinary progress notes, previous nurses' progress notes, medications and treatment record, and ADL Notes.~~
- d. The nurse ~~may will~~ obtain verbal input from ~~other nursing staff members involved in the resident's care. the CNAs or PCA and licensed staff assigned to care for the resident on each shift.~~
- e. If, ~~at any time~~, the licensed nurse determines that approaches on the care plan are incomplete or ineffective, ~~the licensed nurse will make~~ ~~she/he is to make the~~ appropriate

**~~Guidelines Charting for / Documentation / Reporting of~~**

File: **~~C 3.1~~** ~~September, 2009~~ ~~September 8~~ ~~July 176, 2015~~, Revised ~~New~~  
**~~Expectations – Appendix 2 Resident Care by the Licensed Nurse~~**

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~~changes as needed, to add new problems or delete resolved problems, discuss the rationale in the summary note and report changes to the nurse manager and IDT members affected. f. Use Form MR-352 and check the monthly summary box.~~

**REFERENCES:**

\_\_\_\_\_ Health Information Services Universal Chart Order  
\_\_\_\_\_ RAI/MDS Manual

**CROSS REFERENCES:**

~~NPP C 1.0 Admission and Readmission Procedure  
NPP C 1.2 Relocation Procedure  
NPP C 1.3 Discharge Procedure  
NPP C 3.0 Documentation of Resident Care by the Licensed Nurse  
NPP C 3.2 Documentation of Resident Care by Certified Nurse Assistants & Patient Care Assistants  
NPP C 4.0 Physician Notification of a Change in Resident Status  
NPP D 8.0 Post-Mortem Care~~

Adopted: 8/2002; 09/2009

Revised: 09/08/2015

Reviewed: \_\_\_\_\_

Approved: \_\_\_\_\_

New: 9/2009

Bathing Alternatives/Bed Bath

## BATHING ALTERNATIVES/BED BATH

### POLICY:

1. Residents who do not receive tub baths or showers are provided with bathing alternatives, ~~including bed baths.~~
2. Registered nurses in collaboration with the care team are responsible for assessing and planning for the bathing needs and preferences of residents.
3. Individualized bathing preferences (e.g., time of day) are indicated on the care plan front card, at minimum.
4. Licensed Nurses, certified nursing assistants (CNA), and patient care assistants (PCA) may assist residents with bed baths or bathing alternatives.

### PURPOSE:

To ~~provide meet~~ resident's hygiene through alternative bathing techniques. ~~needs and observe skin condition.~~

- ~~1. To provide alternative bathing techniques when usual methods are uncomfortable to the resident either physically or psychologically.~~

### DEFINITION:

Bathing Alternatives include innovative or individualized bathing techniques and approaches for residents who have special bathing needs related to physical, cognitive, behavioral or emotional challenges. Consider alternative bathing methods for any resident who expresses discomfort during bathing or incontinent care due to possible pain, fear, cold, confusion, or aggression.

### PROCEDURE:

#### A. Preparation for Alternative Bathing

- ~~1. Respect resident privacy at all times.~~ Prepare and bring all of bathing supplies in advance and bring to the bedside. If indicated, provide pain medication or other pre-bathing interventions identified on the care plan before proceeding, allowing enough time for effect.
- ~~2.1.~~
- ~~3. Evaluate the resident's specific needs considering cultural influences and personal preferences along with contributing history and conditions such as arthritis, dementia, history of abuse, traumatic brain injury and many other factors influence a resident's comfort level with bathing.~~
- ~~4. During the procedure be aware of any non-verbal signs of discomfort or growing anxiety (facial expressions, clenched fists, tightening of muscles) that may lead to an aggressive outburst. If at any time the resident becomes resistant and/or combative, calmly stop the procedure to avoid emotional trauma.~~
- ~~5. Plan alternative bathing interventions according to specific resident needs. Once a plan of care is determined, it is documented and is to be followed by all caregivers.~~

## Bathing Alternatives/Bed Bath

- ~~6. If indicated, provide pain medication or other pre-bathing interventions identified on the care plan before proceeding, allowing enough time for effect.~~
- ~~7. Approach resident with confident and calm demeanor, while bathing, instruct the resident of each step and give frequent rest periods.~~
- ~~8. If new to the resident, consult with staff who are more aware of the resident's preferences before approaching. It may be necessary to assign only familiar caregivers or to relieve or assist a new caregiver.~~
- ~~9.2.~~
- ~~10. For those who are fearful of bathing introduce yourself and briefly explain what you are about to do, substituting the words "massage" or "spa treatment" instead of "bath".~~
3. Throughout the bath, examine resident's skin condition for any abnormalities, discoloration, rashes or breakdown, and if present report to the licensed nurse.

11.4. Verbally cue resident of each step before proceeding, to alleviate anxiety.

### B. Alternative bathing techniques

For resident who require individualized hygiene plans of care, consult with resident care team (e.g., OT and CNS). Refer to Appendix 1 for Alternative Bathing and Hair Washing Techniques.

### B. Reporting and Documentation

#### C.

- ~~1. Keep the resident warm and covered throughout the procedure, adapting the specific technique to the resident's response. Verbally cue resident of each step before proceeding, to alleviate anxiety.~~
  - ~~a. Place a bath blanket (or towels) and washcloths directly into a washbasin or plastic bag with warm water or use no-rinse foam cleanser. Disposable towelette can be used.~~
  - ~~b. Cover the resident with a warm dry bath blanket (or clean thermal blanket).~~
  - ~~c. Reach under the bath blanket/ thermal blanket to remove the resident's gown or roll the gown up so that the resident is never exposed.~~
  - ~~d. Starting at the feet, unroll the wet cleansing bath blanket or towels under the dry blanket until the resident is completely covered by a warm, wet blanket beneath a warm, dry blanket.~~
  - ~~e. Massage through the washcloth or disposable towelette to cleanse the resident. Beginning at the feet with light pressure and massage is usually more acceptable to the resident than starting with the face. This approach allows the resident to gradually get comfortable with what you are doing and it allows the staff person to watch the residents' reaction, while keeping safe. Face washing can be combined with oral care and grooming and the resident may be able to assist more easily once up.~~
  - ~~f. Coach the resident to wash parts of their body themselves whenever possible:
    - ~~i. If the resident has the physical ability to move a hand and arm, they can usually take part in at least some of the alternative bathing process.~~
    - ~~ii. Having the resident hold a washcloth or towelette may decrease any attempts to hit or scratch and helps give demented residents the tactile cue that it is time to wash.~~
    - ~~iii. Place the washcloth or towelette in the residents' hand and provide simple direction.~~~~
  - ~~g. If the resident resists, STOP and reapproach later, keeping the resident warm and safe before leaving. Continuing to bathe after the resident has resisted, will risk injury, lose the residents trust, and continue to have problems during bathing. Assure the resident by saying,~~

## Bathing Alternatives/Bed Bath

~~“I’m not going to do anything until you are ready.” Stand so that the resident can see you with your hands relaxed and in view.~~

- ~~h. When cleaning the perineal area, be aware that this is the most sensitive area and is best done last. Place the cloth or towelette over the area and allow the resident to get used to it briefly before attempting to cleanse.~~

### ~~2. Alternative hair washing~~

~~The same principal of keeping the resident warm and covered can be applied to hair washing. Vary the technique and the frequency depending on the resident's specific needs. Rinse free foam cleanser is available for residents who are not comfortable with the typical procedure.~~

- ~~a. Position the resident sitting up if possible, preferably up in a chair.~~
- ~~b. Prepare all the equipment ahead including: a basin with warm water and no rinse soap, a towel soaking in the basin, and 1 or more dry towels, a shower cap as needed. Comb or other hair grooming items per the resident's preference.~~
- ~~c. Cover the residents' head and hair with a towel soaked (but not dripping) with warm water with no rinse soap.~~
- ~~d. Massage the hair and scalp through the warm towel, taking care not to pull the residents hair. (Most of the cleaning action is coming from soaking the hair; vigorous scrubbing is not necessary.) A shower cap can be used to keep the wet towel warm longer.~~
- ~~e. Cover the head and hair with a warm dry towel as you remove the wet cleansing towel so that the resident is never sitting with wet, dripping hair.~~
- ~~f. Wrap the head with the towel to soak up as much moisture as possible. (Avoid vigorous rubbing or letting the resident become cold as their hair drips dry.)~~
- ~~g. Allow the resident to rest as needed before combing the hair.~~
- ~~h. Help the resident to comb their own hair whenever possible.~~
- ~~i. Adjust the amount of time you spend handling the residents' hair according to their comfort level. (Some enjoy having their hair groomed while others find it very uncomfortable. If the hair is excessively tangled, come from the bottom and gradually work your way up. Give a rest period and come back later if needed.)~~
- ~~j. Use additional products according to the residents' hair care needs.~~

- ~~3. Clean or dry equipment and the over bed table and report changes/ progress to the licensed nurse.~~

## **B. Reporting and Documentation:**

### 1. CNA / PCA

- a. Report change in resident's condition and pertinent observations regarding skin condition, mental and emotional status, and resident's progress in self-care, to the charge nurse. Report changes in resident preferences.
- b. ~~Complete Record~~ DNCR ~~f~~Form.

### 2. Licensed Nurse

- a. Update the Resident's Care Plan Front Card and pertinent problems as needed. Restorative Nursing care planning templates are available as needed to indicate alternative bathing as a restorative dress/ grooming program.



**Bathing Alternatives/Bed Bath**

**APPENDIX:**

Appendix 1: Alternative Bathing and Hair Washing Techniques

Appendix 2: Resident with Low Vision Bathing Technique

**REFERENCES:**

Bathing the Adult. Richards, S. and Schub, E. authors. CINAHL information Systems; 2013 – electronic access on January 17, 2014.

Bathing without a battle: Personal care of individuals with dementia. Barrick AL et al., editors. New York: Springer; 2001

**CROSS REFERENCES:**

NPP D1 2.0 Resident Activities of Daily Living (Basic Care)-

NPP D 2 3.0 Tub Baths and Showers

Revised: 07/2006; 05/27/2014; 09/08/15

Reviewed: \_\_\_\_\_ 05/27/2014

Approved: \_\_\_\_\_ 05/27/2014

**ALTERNATIVE BATHING AND HAIR WASHING TECHNIQUES – APPENDIX 1**

Place a bath blanket (or towels) and washcloths directly into a washbasin or plastic bag with warm water or use no-rinse foam cleanser. Disposable towelette can be used.

Cover the resident with a warm dry bath blanket (or clean thermal blanket).

Reach under the bath blanket/ thermal blanket to remove the resident's gown or roll the gown up so that the resident is never exposed.

Starting at the feet, unroll the wet cleansing bath blanket or towels under the dry blanket until the resident is completely covered by a warm, wet blanket beneath a warm, dry blanket.

## Bathing Alternatives/Bed Bath

~~Massage through the washcloth or disposable towelette to cleanse the resident. Beginning at the feet with light pressure and massage is usually more acceptable to the resident than starting with the face. This approach allows the resident to gradually get comfortable with what you are doing and it allows the staff person to watch the residents' reaction, while keeping safe. Face washing can be combined with oral care and grooming and the resident may be able to assist more easily once up.~~

~~Coach the resident to wash parts of their body themselves whenever possible:~~

~~If the resident has the physical ability to move a hand and arm, they can usually take part in at least some of the alternative bathing process.~~

~~Having the resident hold a washcloth or towelette may decrease any attempts to hit or scratch and helps give demented residents the tactile cue that it is time to wash.~~

~~Place the washcloth or towelette in the residents' hand and provide simple direction.~~

~~If the resident resists, STOP and reapproach later, keeping the resident warm and safe before leaving. Continuing to bathe after the resident has resisted, will risk injury, lose the residents trust, and continue to have problems during bathing. Assure the resident by saying, "I'm not going to do anything until you are ready." Stand so that the resident can see you with your hands relaxed and in view.~~

~~When cleaning the perineal area, be aware that this is the most sensitive area and is best done last. Place the cloth or towelette over the area and allow the resident to get used to it briefly before attempting to cleanse.~~

~~Alternative hair washing: The same principal of keeping the resident warm and covered can be applied to hair washing. Vary the technique and the frequency depending on the resident's specific needs. Rinse free foam cleanser is available for residents who are not comfortable with the typical procedure.~~

~~Position the resident sitting up if possible, preferably up in a chair.~~

~~Prepare all the equipment ahead including: a basin with warm water and no rinse soap, a towel soaking in the basin, and 1 or more dry towels, a shower cap as needed. Comb or other hair grooming items per the resident's preference.~~

~~Cover the residents' head and hair with a towel soaked (but not dripping) with warm water with no rinse soap.~~

~~Massage the hair and scalp through the warm towel, taking care not to pull the residents hair. (Most of the cleaning action is coming from soaking the hair; vigorous scrubbing is not necessary.) A shower cap can be used to keep the wet towel warm longer.~~

~~Cover the head and hair with a warm dry towel as you remove the wet cleansing towel so that the resident is never sitting with wet, dripping hair.~~

~~Wrap the head with the towel to soak up as much moisture as possible. (Avoid vigorous rubbing or letting the resident become cold as their hair drips dry).~~

~~Allow the resident to rest as needed before combing the hair.~~

~~Help the resident to comb their own hair whenever possible.~~

~~Adjust the amount of time you spend handling the residents' hair according to their comfort level. (Some enjoy having their hair groomed while others find it very uncomfortable. If the hair is excessively tangled, come from the bottom and gradually work your way up. Give a rest period and come back later if needed).~~

~~Use additional products according to the residents' hair care needs.~~

## **ALTERNATIVE BATHING AND HAIR WASHING TECHNIQUES – APPENDIX 1**

1. Place a bath blanket (or towels) and washcloths directly into a washbasin or plastic bag with warm water or use no-rinse foam cleanser. Disposable towelette can be used.
2. Cover the resident with a warm dry bath blanket (or clean thermal blanket).
3. Reach under the bath blanket/ thermal blanket to remove the resident's gown or roll the gown up so that the resident is never exposed.
4. Starting at the feet, unroll the wet cleansing bath blanket or towels under the dry blanket until the resident is completely covered by a warm, wet blanket beneath a warm, dry blanket.
5. Massage through the washcloth or disposable towelette to cleanse the resident. Beginning at the feet with light pressure and massage is usually more acceptable to the resident than starting with the face. This approach allows the resident to gradually get comfortable with what you are doing and it allows the staff person to watch the residents' reaction, while keeping safe. Face washing can be combined with oral care and grooming and the resident may be able to assist more easily once up.
6. Coach the resident to wash parts of their body themselves whenever possible:
  - a. If the resident has the physical ability to move a hand and arm, they can usually take part in at least some of the alternative bathing process.
  - b. Having the resident hold a washcloth or towelette may decrease any attempts to hit or scratch and helps give demented residents the tactile cue that it is time to wash.
  - c. Place the washcloth or towelette in the residents' hand and provide simple direction.
7. If the resident resists, STOP and reapproach later, keeping the resident warm and safe before leaving. Continuing to bathe after the resident has resisted, will risk injury, lose the residents trust, and continue to have problems during bathing. Assure the resident by saying, "I'm not going to do anything until you are ready." Stand so that the resident can see you with your hands relaxed and in view.
8. When cleaning the perineal area, be aware that this is the most sensitive area and is best done last. Place the cloth or towelette over the area and allow the resident to get used to it briefly before attempting to cleanse.
9. Alternative hair washing: The same principal of keeping the resident warm and covered can be applied to hair washing. Vary the technique and the frequency depending on the resident's specific needs. Rinse free foam cleanser is available for residents who are not comfortable with the typical procedure.
  - a. Position the resident sitting up if possible, preferably up in a chair.
  - b. Prepare all the equipment ahead including: a basin with warm water and no rinse soap, a towel soaking in the basin, and 1 or more dry towels, a shower cap as needed. Comb or other hair grooming items per the resident's preference.
  - c. Cover the residents' head and hair with a towel soaked (but not dripping) with warm water with no rinse soap.

- d. Massage the hair and scalp through the warm towel, taking care not to pull the residents hair. (Most of the cleaning action is coming from soaking the hair; vigorous scrubbing is not necessary.) A shower cap can be used to keep the wet towel warm longer.
- e. Cover the head and hair with a warm dry towel as you remove the wet cleansing towel so that the resident is never sitting with wet, dripping hair.
- f. Wrap the head with the towel to soak up as much moisture as possible. (Avoid vigorous rubbing or letting the resident become cold as their hair drips dry).
- g. Allow the resident to rest as needed before combing the hair.
- h. Help the resident to comb their own hair whenever possible.
- i. Adjust the amount of time you spend handling the residents' hair according to their comfort level. (Some enjoy having their hair groomed while others find it very uncomfortable. If the hair is excessively tangled, come from the bottom and gradually work your way up. Give a rest period and come back later if needed).
- j. Use additional products according to the residents' hair care needs.

Post-Mortem Care

## POST-MORTEM CARE

### POLICYIES:

1. Following physician pronouncement of death, any nursing staff member may provide post mortem care which is ~~always respectful~~ respectful, mindful, and in accordance with resident/families' religious and cultural practices.
- ~~2. Death notification of the family or designated significant other, as designated on the Resident Care Plan (RCP) or face sheet, preferably is completed & communicated by the physician who has pronounced the death; in rare cases notification may be completed by the nurse or social worker. team member who has the closest relationship with this family or significant other~~
- ~~2.~~
- ~~3.~~
3. Once the resident's death is pronounced ~~dead by the physician~~, the licensed Nurse (LN) will notify the family or decision-maker to contact the private prearranged (pre-need) funeral service. If funeral arrangements were not completed ~~completed~~, ~~the deceased body will be transported to the LHH morgue during usual business hours (8AM-800 until 2300-110PM).~~
- ~~3. Refer to hospital policy LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates -for information about access to death certificates. -call the morgue or private mortuary (arranged by the resident's family or and the family visitation has occurred, the licensed nurse (LN) will call the morgue. Family of Surrogate Decision Maker (SDM) must notify a pre-arranged private mortuary to remove the body.~~
- ~~4.~~
- ~~5. Use of the shroud for transporting the deceased resident's body to the morgue is not required, as long as ID bracelet remains intact for proper identification, unless there are excessive body secretions or odor or other indications for wrapping the body.~~
- 4.

### PURPOSE:

To describe the procedures for care of the resident after death.

### PROCEDURES:

#### A. Equipment

1. Each neighborhood will have
  - a. "Post-Mortem care pack" including shroud, tape, tags, body bag if necessary
  - b. Property envelopes/packing boxes

#### B. Notifications

1. After the resident has been pronounced by the physician, the licensed nurse will notify:
  - a. RCT members if the physician was unable to contact the family or significant other
  - b. Nurse Manager or Nursing Operations Manager (when not weekday)
  - c. Social Worker

## Post-Mortem Care

- d. Clergy if requested by resident or family
- ~~a. Admissions and Eligibility on weekdays between 0800 and 1630~~
- ~~b. After the resident has been pronounced by the physician, the licensed nurse willis to notify:~~
- ~~c. Family or significant other designated on the care plan or face sheet unless the physician has done so. In those cases where RCT members if the physician was is unable to contact the family or significant other.~~
- ~~d. Nurse Manager or Nursing Operations Manager (when not weekday).~~
- ~~e. The Social Worker.~~
- ~~f. Clergy if requested by resident or family.~~
- ~~g. Admissions and Eligibility on weekdays between 0800 and 1630.~~
- ~~h.e.~~

~~Morgue for the body to be picked up. (Family/SDM is responsible for contacting privately arranged mortuary).~~

### **B.C. Preparing the body for viewing**

1. Be attentive to religious/cultural preferences listed on the RCP. Refer to Attachment 1.
- 1-2. Bathe the body, apply clean dressings (if needed), and comb hair. Align the body on the bed with the head on a pillow. Cover the resident, from chest level to toes, with a clean sheet or bedspread. Put bed in low position and side rails down. Close bedside curtains or door when appropriate for privacy.
- 2-3. Remove jewelry if possible. Place wedding ring or other jewelry in a labeled storage envelope with label and locked securely in Nurse Manager Office give it to the Nurse Manager for safety keeping neighborhood safe/ locked cupboard for family retrieval. Update the Property Inventory. Tape wedding ring on finger if it cannot be removed easily.
- 3-4. Leave the resident's hands outside of the bedspread unless visitors prefer that they be tucked under bedclothes.
- 4-5. If lips will not stay closed, use a small towel or soft collar under the chin to help close lips, especially if dentures will not stay in place.
- 5-6. On South 3, a scarf is sometimes placed around neck to hide collar or towel, and quilt or comforter and special pillow case placed for viewing.
- 6-7. If eyes will not remain closed, use a tiny dot of Vaseline between lids.
- 7-8. Remove medical/hospital equipment on bedside/room.
8. Bring one or two extra chairs for family comfort. Leave tissue box, family photographs and flowers if available and water pitcher and cups.
- 9.
9. ~~After the visitors leave, staff may prepare the body to be transported to the morgue or mortuary. (Note: from 11PM to 8AM, the deceased body will not be transported to the LHH morgue and instead remain in the room).~~
10. ~~If the deceased resident is in an open double or triple room and has roommates, relocate to a private room for comfort and privacy for the family/friends.~~

### **C.D. Viewing of the Body**

## Post-Mortem Care

1. If the family requests to view the resident's body, inform the family that the viewing may should occur in the resident's room up to within 8 hours after the from the time of death pronouncement or after transport to the morgue in the viewing room adjacent to the new morgue.
2. ~~Be attentive to religious/cultural preferences listed on the RCP, such as 8 hours of chanting, gender requirements for nurse preparing body, special dressing or immediate burial. If there are special cultural/religious traditions that require extended hours beyond the 8 hours, the unit will communicate with Nurse Manager or Nursing Operations Nurse Manager so that special arrangements are accommodated.~~
1. ~~(Note: from 10PM to 8AM, the deceased body will not be transported to the LHH morgue and instead remain in the room)~~
3. If the deceased resident is in an open double or triple room and has roommates, relocate the deceased's body to a private room for privacy for the family/friends if available. Otherwise the deceased can be transported to the morgue; there is a viewing room for family/friends next to the new morgue.  
  
~~LN will call the morgue to arrange an appropriate time for the body to be picked up that does not occur during group activities in Great Room. NOTE: When funeral arrangements have been made (as per medical record/care plan), the family or decision maker will be asked to contact mortuary to pick up body from LH and to arrange an appropriate time for the body removal that does not occur during group activities in the Great Room.~~
2. ~~; LH staff can only contact morgue to pick up body.~~
- 3.4.
4. ~~Be attentive to cultural preferences listed on the RCP. For example some cultures want the resident to be dressed in certain clothing, 8 hours of chanting after death, only caregivers of same gender may attend to the body, positioning the body in a certain way, or require immediate burial.~~
5. ~~If funeral arrangement has not been made, the deceased would be transported to the morgue.~~
6. If family members or friends are unable to come to the unit for viewing in a reasonable timeframe, staff from the unit of the deceased, may assist with viewing in the room adjacent to LHH new morgue. Gurney and other supplies are available in the LHH new morgue if needed to clean the face.

### ~~D.E.~~ Preparation of the Body for Transport to the Morgue or Mortuary:

~~Note: from 11PM to 8AM, the deceased body will not be transported to the LHH morgue and instead remain in the room unless absolutely necessary in which case contact Nursing Operations Manager for assistance with assigning 2-3 staff members from other units to assist the sending unit staff.~~

1. Lay the body flat in bed. Do not remove identification band.
2. If there is any drainage from the mouth or rectum, place an abdominal/ABD pad over orifice.
3. ~~If there are excessive body secretions or body odor, A~~ shroud will be used to transport the body to the morgue after completing the complete following:

## Post-Mortem Care

- a. Place arms at sides, remove dressings and tubes, and insert clean dentures. If unable to insert dentures, place dentures in well-labeled property envelope (name, hospital number, date of expiration) and tape to shroud over chest.
  - b. Make three tags, each containing the person's name, date and time of death pronounced by Dr. \_\_\_\_\_. Remark on tag if wedding band is taped to finger and if dentures are in mouth. Stamp addressograph on the reverse side of tags.
    - i. Tie string of one tag on right big toe or to another extremity.
    - ii. Tie second tag to zipper-pull on the outside of the body bag.
    - iii. Secure the 3<sup>rd</sup> tag to the LHH morgue refrigerated unit if not picked up by funeral director.
  - c. Place shroud under body in diamond fashion, so that the head is at one point and the feet at the opposite point:
    - i. Fold bottom of shroud over feet.
    - ii. Then fold both sides towards the center of the body. Tape shroud closed.
    - iii. Fold top corner loosely over the face. Tape shroud closed.
4. Once the funeral home morgue attendant arrives to pick up the body, accompany the funeral home morgue attendant to the room.
5. From 230011PM to 08008AM, the deceased body will remain in their room and will not be transported to the LHH morgue. If absolutely necessary to transport the body to the morgue during that time, because of roommate discomfort or awareness, contact Nursing Operations Manager to assign 2-3 staff members from other units to assist the sending unit staff.
- 5.6. If the body is to be transported to LHH morgue, at least 3-4 staff members are required to safely transfer the body from the gurney to the refrigerated unit while maintaining the dignity of the deceased.
7. After the body has been transported, strip and wash the resident's bedside, unless it is at night and the cleaning of the bedside ~~unit would~~ disturb other residents ~~nearby~~.

## F. Release of Body to the Pre-Arranged Funeral/Mortuary Services home Morgue (LH contracted vendor) or Mortuary (family contracted service) attendant

1. If Nursing receives information about pre-need or prearranged Funeral plans, the nurse will notify the MSW for follow-up. If confirmed, the MSW will provide copies to A&E and place a copy in resident's chart.
2. The resident with "Pre-Need" or prior funeral arrangements will have their medical record flagged as followed:
  - a. A&E will fill ~~in value~~ the "Pre-Need" field in Invision and flag the A&E file by writing or stamping "PRE-NEED" on the front of ~~A&E file~~ the chart.
  - b. Nursing or Social Worker will placed the "PRE-NEED" in the Advanced Directives section in ~~will also tag~~ the resident's/patient's ~~m~~Medical chart and will document in the front card of the RCP under preferences. ~~on the unit~~.



## Post-Mortem Care

- c. "Pre-Need" (prior to funeral arrangements) form will be stamped "Do Not Remove".
- ~~1.3.~~ During business hours 0800 ~~to~~ -1630, ~~morgue or funeral home~~/mortuary attendant will go to A & E to sign on death registry for body pickup.
- ~~2.4.~~ During non-business hours ~~1630 to 0800~~, weekends and holidays, ~~morgue or funeral home~~/mortuary attendant will go to Operations Nursing Office to sign on death registry prior to body pickup.
- ~~3.5.~~ For pickup by ~~funeral home~~/mortuary (~~family contracted service~~) attendant, a form with family signature releasing the body to the mortuary is to be submitted.
6. Staff from the unit of the deceased, are required to go to the morgue to unlock door for morgue attendant.
- ~~— If Nursing receives information about "Pre-Need or Pre-Arrangement", the nurse will notify the MSW for follow-up. If confirmed, the MSW will provide copies to A&E and place a copy in resident's chart.~~
- ~~— The resident with "Pre-Need" or prior arrangement will have their medical record flagged as followed:~~
- ~~— A&E will value the "Pre-Need" field in Invision and flag the A&E file by writing or stamping "PRE-NEED" on the front of the chart.~~
- ~~— Nursing will also tag the resident's/patient's Medical chart on the unit.~~
- a. "Pre-Need" (prior to funeral arrangements) form will be stamped "Do Not Removed".

## G. Disposition of Properties

1. Refer to ~~LHHHWP~~ PP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
- ~~2.~~ Assemble resident's property. Obtain a packing box and storage envelopes as needed.
- ~~3.~~
- ~~4.2.~~ Check the resident's bedside stand and wardrobe. Assure that property is safely stored in the designated storage room (K-5). Check with the Nurse Manager or Charge Nurse the Nurse Manager's Office if there are any other properties stored in the Nurse Manager's office or storage room. office will check the neighborhood safe or locked cupboard or in A & E. Assure that property is safely stored.
- ~~5.3.~~ Update property checklist:
- Make certain property sheet is stamped with resident's name, neighborhood number, and hospital number.
  - Write on the original form in the "Remarks" section: date, time, pronounced expired by Dr. \_\_\_\_\_. Itemize property and its disposition to either Admissions and Eligibility or the Nursing Neighborhood Station.
  - Make a photocopy. Place original property sheet in resident's chart and securely attach the photocopy to the property.
  - Store valuables or money in an envelope with label and locked securely in Nurse Manager Office Monday through Friday, 0800 to 1630 (except holidays), take valuables to Admissions and Eligibility, take money to Patient Accounts (0900 to 1500).

**Post-Mortem Care**

4. Check with the Nurse Manager or Charge Nurse if there are any other properties stored in the Nurse Manager's office or storage room.

~~6.5.~~ Responsible party can sign the property sheet and take the valuables before they leave after viewing the body or may return during the following few days.

**H. Documentation**

1. Interdisciplinary Notes:-

- a. Document resident's condition/decline prior to the death, the time of death, the name of the physician who pronounced the death, and disposition of the body.
- b. Document information regarding resident's dentures, ring(s), and other property.
- c. Record if this will be a coroner's case.
- d. Document the time when the body was picked up by the morgue or mortuary.

2. Complete Chronological Record of Admissions, Transfers, and Discharges

3. Property Sheet (See also Section G)

Itemize list of property and information regarding disposition of property and valuables, including any rings and dentures. Make duplicate copy to attach to property.

4. Invision/LCR: ~~Update-Complete~~ census.

~~7.6.~~ Resident Trust's Funds: Refer to LHHPP 50-02 Resident Trust Fund

~~Record death on the Census AOD report.~~

**ATTACHMENT:**

Attachment 1 - Understanding Cultural and Religious Preferences for Care of the Dying and the Deceased

~~Understanding cultural/religious preferences related care of the dying and the deceased~~

~~In resident RCC or in one to one conversation with resident and family or legal decision makers ask the following:~~

~~Are there any religious or cultural practices we should know about in order to honor you or your loved one dying?~~

~~For example:~~

~~Religious/spiritual services (anointing of the sick, chanting)~~

~~Cleaning or preparation of the body~~

~~gender of caregiver who is caring for the body~~

~~particular or special clothing that the resident should wear~~

~~timeliness of burial~~

**Post-Mortem Care**

**CROSS REFERENCES:**

~~LHHPP 29-08 Laguna Honda Hospital Temporary Morgue Services (needs to be deleted as refers to BAC)~~

~~LHHPP 24-02 Notice of Resident Death~~

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

~~LHHPP 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition~~

~~LHHPP 50-02 Resident Trust Fund~~  
~~LHHPP 50-02 Resident Trust Fund~~

~~LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates~~

~~MSPP C01-01 Patient Expiration~~

~~MSPP C01-02 Autopsy Policy & Procedures~~

~~MSPP C01-03 Organ Tissue Donation Request~~  
~~LHHPP 296-069 Guidelines for Handling Decedents and Use of Morgue and Death Certificates~~

~~Include entire MSPP C01 Death (3 policies) Language re notification must be consistent with other policies that indicate MD will notify next of kin of death see 24-11~~

Revised: 8/2003; 3/2009, 10/2010, 3/27/2012, ~~09/0876/129/2015~~

Reviewed: ~~10/27/2010; 03/27/2012; 7/19/2015~~

Approved: ~~03/27/2012~~

~~Reviewed: RP; HM; HY; LZ and AH, CNs AM and PM shift~~

~~Reviewed by \_\_\_\_\_ and no revision recommended at this time.~~

~~Approved: \_\_\_\_\_~~

For Ghe use only:

Date sent to Policy Reviewer **04/23/14**

Date received from Policy Reviewer \_\_\_\_\_

Date reviewed by NEC \_\_\_\_\_

Date approved by NEC \_\_\_\_\_

Date routed to MEC \_\_\_\_\_

Date emailed to Karina \_\_\_\_\_

## Understanding Cultural and Religious Preferences for Care of the Dying and the Deceased – Attachment 1

In resident RCC or in one to one conversation with resident and family or legal decision makers ask the following:

1. Are there any religious or cultural practices we should know about in order to honor you or your loved one dying? For example:
  - a. Religious/spiritual services (anointing of the sick, chanting)
  - b. Cleaning or preparation of the body
  - c. Gender of caregiver who is caring for the body
  - d. Particular or special clothing that the resident should wear
  - e. Timeliness of burial

New: ~~07/19~~~~09/08~~/2015

Reviewed: \_\_\_\_\_

Approved: \_\_\_\_\_

## **BEHAVIORAL RISK ASSESSMENT AND CARE PLANNING and GUIDELINES FOR CARE PLANNING**

### **POLICY:**

1. Residents have the right to be safe and free from harm.
2. The existence of aggressive behavior or the likelihood of being a target of aggressive behavior that places residents and staff at risk is regularly assessed in all residents.
3. The Registered Nurse (RN) is responsible for completing a behavioral risk assessment on each resident upon admission, quarterly, and whenever there is a change of condition, and upon transfer to another neighborhood.

### **PURPOSE:**

1. To maintain safe environment and enhance the therapeutic milieu.
2. To identify residents whose behaviors pose potential risks to themselves and/or to others.

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### **PROCEDURE:**

#### **A. Using the Nursing Assessment Behavioral Risk Form**

1. The Nursing Assessment for Behavioral Risk form (MR 340) is the assessment tool to be used as part of the comprehensive Minimum Data Set (MDS).
  - a. Section 1 asks eight (8) questions that assess the resident to determine if he/she is at risk for aggressive behaviors directed at others.
    - i. If any question is answered with a *yes*, the nurse is access the online care plan template (located under *LHH intranet/Forms/ Nursing Care Plans*) to address the problem "At risk for aggressive behavior". The care plan then is reviewed and further individualized by the Resident Care Team (RCT).
    - ii. If a ~~question(s) is (are) answered yes and the circumstances determining the yes response is not likely to reoccur or is indicative of behaviors not related to aggression,~~ nurse ~~may~~ determines that an aggressive behavior care plan is not indicated. ~~The nurse then writes~~ an explanation is documented as to ~~why a care plan is not indicated~~ the reason. For example  
"The resident's increased psychomotor activity (pacing) is related to side effects of medication effects and not a related to aggression"
  - b. Section 2 asks six (6) questions that assess the resident's risk for being a target of aggression.
    - i. If any question is answered with a *yes*, the nurse is to access the online care plan template (located under *LHH intranet/Forms/ Nursing Care Plans*) to address the problem "At risk for being a target of aggression". The care plan then is reviewed and further individualized by the RCT.

## B. Assessment and Reassessment time parameters.

1. The Behavioral Risk Assessment is completed as part of a comprehensive Minimum Data Set ~~completed as part of a comprehensive Minimum Data Set~~ (MDS) and therefore is completed:
  - a. Within two (2) weeks of admission
  - b. At the time of a significant change of condition
  - c. Annually
  - d. Quarterly
2. In addition, the assessment is completed
  - a. Within two (2) weeks of relocation to another neighborhood
  - b. When otherwise clinical indicated and at the request of any RCIDT member

## C. Guidelines to Develop Behavioral Risk Care Plans

1. Refer to Attachment 1: Guidelines to Develop Behavioral Risk Care Plans-

### **ATTACHMENTS:**

Attachment 1: Guidelines to Develop Behavioral Risk Care Plans ~~Guidelines to Develop Behavioral Risk Care Plans~~

Attachment 2: Nursing Assessment for Behavioral Risk (MR 340)

Attachment 3: Behavioral Monitoring Records: Code Sheet (MR 330A) and Log Sheet (MR 330B)

Instructions for completing a Nursing Assessment for Behavioral Risk

Nursing Assessment for Behavioral Risk (MR 340)

### **CROSS REFERENCES:**

LHHPP 23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference

LHHPP 24-01 ~~Elopement Response~~Missing Resident Procedures

LHHPP 22-01 Abuse Protection Program: Prevention, Recognition, Reporting

### **ATTACHMENTS:**

Guidelines to Develop Behavioral Care Plans

Instructions for completing a Nursing Assessment for Behavioral Risk

Nursing Assessment for Behavioral Risk (MR 340)

Adopted: June 2005

**Behavioral Risk Assessment and**  
**~~8 July 179, 20154~~, Revised**  
**~~Guidelines for Care Planning~~ **And Care Planning****

File: **G 6.0** ~~May 27 222~~ **September**

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Revised: 05/27/14; ~~07/1909/08/2015~~

Reviewed: ~~05/27/14~~ \_\_\_\_\_

Approved: ~~05/27/2014~~ \_\_\_\_\_

## **Appendix Attachment 1: Guidelines to Develop Behavioral Risk Care Plans**

### **General Principles To Consider When Care Planning Interventions For Behaviors That Place a Resident At Risk:**

1. Consider to what degree the resident can think consequentially. An agreement or behavioral contract can only work if the resident has the capacity to understand that there are consequences to his/her behaviors.
2. Consider the resident's ability to comprehend language.
3. Determine patterns of behavior. What time of day is most difficult? Do you see more of the behavior before meals, when visitors are present? Why?
4. Always provide a substitute behavior. When modifying behavior, develop ideas based on residents preference that can redirect them.

#### **A. Care Plan for Residents At Risk For Aggressive Behaviors Directed At Others:**

In preparation for designing interventions, consider having a team member who has a good relationship with the resident, ask the resident when the resident is calm:

1. "What are the things that cause you to become upset?"
2. "What do you experience which can be described as a warning sign?"
3. "What can staff do to help you remain calm?"

By talking, before the incident, the resident may identify ways that others may be of help. The resident may be able to identify the triggers, which set him/her off, or the staff may be able to tell the resident what they think are the triggers. Staff may gain insight as to what is most likely to be helpful. It is always a therapeutic advantage if the resident and the team can agree on what actions can be taken if the resident is showing signs of losing control. This type of interaction helps the resident recognize that the team does not see him/her as bad, but rather as having a problem.

#### **B. Care Plan for Aggressive Behaviors**

##### 1. To prevent aggression, consider care planning the following interventions:

- a. For residents who can communicate their feelings/ follow directions:
  - i. Encourage the resident to identify his/her triggers for aggression and instruct them to do relaxation exercises "When you feel yourself becoming angry and your body becomes hot, take ten deep breaths.
  - ii. Encouraging the resident to write down his/her feelings/grievances.
  - iii. Encourage the resident and help the resident to call a friend or visit with another resident.
  - iv. Refer to anger management class.
  - v. If the resident can think consequentially and understands the effect of his behavior (and this is documented), hold the resident to a predetermined agreement which has been discussed.
- b. For all residents
  - i. Decrease environmental stimuli, decrease the noise level, turn off the radio or TV, isolate resident.
  - ii. Distract the resident with an activity that they enjoy.
  - iii. If the aggression is a result of fear, reassure the resident about that which he/she is afraid.



## **Behavioral Risk Assessment Guidelines to Develop Behavioral Risk**

File: **G 6.0** ~~May 22~~ ~~September 8, 2015~~ ~~January 29, 2013~~, Revised

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- iv. Offer support and not censorship “You seem upset, come walk with me”. You seem angry with Mike, sit here and tell me about it”.
- i. Normalize feelings of anger directed at intrusive residents. State “Your feelings are understandable”. “I think it is normal to be upset with her.” “It is hard to live here.” Let the resident know his/her feelings are okay and they need to control his/her behavior. Help the resident separate feelings from actions.
- ii. Instruct and model appropriate responses to residents who are intrusive. “Call any of the staff if she takes your things.”
- iii. Reassure the resident that the intrusive behavior is not intentional. “Her climbing into your bed is very annoying, but she can’t help it. She is confused and does not know what she is doing.”
- iv. Recognize and praise behaviors that are acceptable.
- v. You may call the Sheriff Office when a uniform will help set limits. Tell the officers in advance about the situation and let them know what it is you would like them to do.

## **2. Interventions for Resident Who Is A Target Of Aggression:**

- a. Keep/move the resident to an area where he/she can be observed more easily.
- b. Encourage the resident to stay in his own space. Make the space attractive and interesting by providing pictures of the family, puzzles, rummage boxes, favorite afghans, etc
- c. If the resident can think consequentially, consider a behavioral agreement to prevent him/her from intruding on others.
- d. Redirect resident based on cognitively and neurologically therapeutic activities such as folding laundry, matching socks, collating paper, or etc.
- e. Provide videos of old and familiar movies.
- f. Determine if the behavior, which places resident at risk, occurs as a response of being tired and plan for rests and naps. If the behavior occurs at night, keep the resident awake during day and encourage a consistent bedtime.
- g. Determine if resident is hungry and provide for snacks.
- h. Insure that resident is hydrated and not constipated which may lead to increased wandering.
- a.i. Use CDs for relaxation.
- i. If determined to be appropriate by the RCT, refer to Laguna Premier Club (LPC)

## **C. Care Plan for Resident At Risk for Elopement**

### **1. In preparation for care planning:**

- a. Try to determine the purpose the behavior serves. Ask the resident in a concerned matter of fact way for example:  
“Why do you want to leave?” or “What is it that makes up upset?”  
“What do you want?” or “What is it you want to do?”  
Where do you want to go?”

- b. Consider the degree of impairment. Pointing out reality is not always helpful.

### **2. Interventions for eloping residents:**

- a. If the resident asks for money or bags, determine through conversation and observation the resident’s agenda. “Why do you want money?”; “What do you want to buy?”; “Are you thinking of leaving?” If the request is an attempt to feel more secure while on the unit, consider the following interventions:

## **Behavioral Risk Assessment Guidelines to Develop Behavioral Risk**

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- i. Provide a small amount of change, fake money, a wallet, a purse or an athletic bag that the resident can carry around.
- ii. Take the resident to the bank.
- iii. Reassure her that all her meals and medications have been paid for in advance; If the resident's agenda is to get money or gather her possessions to leave, consider "Let's wash your clothes now"; "The bank is closed now, let's wait till the morning".
  
- b. Use a stalling tactic like "It is much too cold today to go out" or "The buses are not running now."
- c. Provide special attention, sitting together, one-to-one activity.
- d. If the resident appears angry or frightened, consider having a friendly team member interact or consider someone less familiar and more neutral to interact.
- e. If the resident has an agenda "My mother wants me home, she will be worried", reassure the resident "I will call her and tell her you are here with me."
- f. Assess for over tiredness. Provide for rest periods and naps during the day.
- g. Assess for tobacco craving. Provide nicotine patch, gum, sugarless candy.
- h. Assess for discomfort/pain. Provide analgesia for arthritis, etc.
- i. Assess for hunger. Provide a snack.
- j. Ask physician for a psych/ SATS consult.
- k. Assess reside who are exit seeking, engage resident in activity.
- l. Relocate bed away from door or where more direct observation is possible.
- m. Use Resident Locator System (RLS) and seat alarms.
- n. Distract with planned group activities, 1-to-1 conversations, folding linens, helping staff carry items.
- o. Help resident to develop a relationship with other residents, volunteers to decrease loneliness, to increase socialization on the unit.
- p. Establish a time/routine for resident to make or receive phone calls from family and friends.
- q. Display photos, letters, afghans and other personnel objects near resident's bed.
- r. If resident attempts to leave, remind resident that his family knows he is here and they would be disappointed and worried if he went somewhere else

### **B-D. Steps in De-Escalation**

1. Consider the following interventions and care plan for an immediate threat:

- a. Stay calm.
- a-b. Remove any person(s) who may be in danger. Attempt to isolate the resident.-
- b-c. One staff member gets the resident's attention by calling his/her name and in a loud firm voice says "STOP JOHN".
- e-d. One staff member using clear short sentences tells the resident what he needs to do. "John, sit down in that chair now"; "John, put that glass down on the table now"; "John, take a deep breath".
- d-e. Do not tell the resident to feel differently. Do not tell him/her to calm down. Provide direct orders in a command such as, "Walk away from Mike now".
- e-f. Give the resident space, do not crowd him/her, and do not overwhelm him/her. Only one staff member should speak at a time.

### **CROSS-REFERENCES:**

LHHPP 24-01 Missing Resident Procedures

## **Behavioral Risk Assessment Guidelines to Develop Behavioral Risk**

File: **G 6.0** ~~May 22~~ ~~September 8, 2015~~ ~~January 29, 2013~~, Revised

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#### LHHPP 75-06 Dr. Grey Code

~~Remove any person(s) who may be in danger. Attempt to isolate the resident.~~

To prevent aggression, consider care planning the following interventions:

- ~~Decreasing the stimuli, decrease the noise level, turn off the radio or TV, isolate resident.~~
- ~~Distract the resident, put on the radio, put on the TV, ask the resident to go to his/her bed; ask the resident to count to ten in an activity that they enjoy.~~
- ~~Encourage the resident to identify his/her triggers for aggression and instruct them to do relaxation exercises "When you feel yourself becoming angry and your body becomes hot, take ten deep breaths".~~
- ~~Encourage the resident to paint, to work with clay.~~
- ~~Encouraging the resident to write down his/her feelings/grievances.~~
- ~~Encourage the resident and help the resident to call a friend or visit with another resident.~~
- ~~Refer to anger management class.~~
- ~~If the aggression is a result of fear, reassure the resident about that which he/she is afraid.~~
- ~~Offer support and not censorship "You seem upset, come walk with me". "You seem angry with Mike, sit here and tell me about it".~~
- ~~Call IP when a uniform will help set limits. Tell the police officers in advance about the situation and let them know what it is you would like them to do.~~
- ~~If the resident can think consequentially and understands the affect of his behavior (and this is documented), hold the resident to a predetermined agreement which has been discussed.~~
- ~~Normalize feelings of anger directed at intrusive residents. State "Your feelings are understandable". "I think it is normal to be upset with her." "It is hard to live here." Let the resident know his/her feelings are okay and they need to control his/her behavior. Help the resident separate feelings from actions.~~
- ~~Instruct and model appropriate responses to residents who are intrusive. "Call any of the staff if she takes your things." "Her shouting is awful, let's walk down the hall."~~
- ~~Reassure the resident that the intrusive behavior is not intentional. "Her climbing into your bed is very annoying, but she can't help it. She is sick confused and does not know what she is doing."~~
- ~~Teach and encourage relaxation techniques.~~
- ~~Recognize and praise behaviors that are acceptable. "I am glad you called me and can complain about the noise without hitting anyone. That is real progress."~~

Interventions for Residents at Risk for being Targets of Aggression:

- ~~Keep/move the resident to an area where he/she can be observed more easily.~~
- ~~Encourage the resident to stay in his own space. Make the space attractive and interesting by providing pictures of the family, puzzles, rummage boxes, favorite afghans, etc.~~
- ~~If the resident can think consequentially, consider a behavioral agreement to prevent him/her from intruding on others~~
- ~~Redirect resident to TV, folding laundry, matching socks, collating paper.~~
- ~~Provide videos of old and familiar movies.~~
- ~~Determine if the behavior, which places resident at risk, occurs as a response of being tired and plan for rests and naps. If the behavior occurs at night, keep the resident awake during day and encourage a consistent bedtime.~~
- ~~Determine if resident is hungry and provide for snacks.~~
- ~~Insure that resident is hydrated and not constipated which may lead to increased wandering.~~
- ~~Use CDs for relaxation.~~

Interventions for Residents at Risk for Elopement:

## **Behavioral Risk Assessment Guidelines to Develop Behavioral Risk**

File: ~~G 6.0 May 22~~ **September 8, 2015** ~~January 29, 2013~~, Revised

### **Guidelines for Care Planning – Appendix Attachment 1**

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- ~~In preparation for care planning:~~
- ~~Try to determine the purpose the behavior serves. Ask the resident in a concerned matter of fact way “Why do you want to leave?” or “What is it that makes up upset?”; “What do you want?”; “Where do you want to go?” “What is it you want to do?”~~
- ~~Consider the degree of impairment. Pointing out reality is not always helpful.~~

#### Consider:

- ~~If the resident asks for money or bags, determine through conversation and observation the resident’s agenda. “Why do you want money?”; “What do you want to buy?”; “Are you thinking of leaving?” If the request is an attempt to feel more secure while on the unit, consider the following interventions:~~
  1. ~~Provide a small amount of change, fake money, a wallet, a purse or an athletic bag that the resident can carry around.~~
  2. ~~Take the resident to the bank on the second floor.~~
  3. ~~Reassure her that all her meals and medications have been paid for in advance; If the resident’s agenda is to get money or gather her possessions to leave, consider “Let’s wash your clothes now”; “The bank is closed now, let’s wait till the morning”.~~
- ~~Use a stalling tactic like “It is much too cold today to go out” or “The buses are not running now.”~~
- ~~Provide special attention, sitting together, 1 to 1 activity.~~
- ~~If the resident appears angry or frightened, consider having a friendly team member interact or consider someone less familiar and more neutral to interact.~~
- ~~If the resident has an agenda “My mother wants me home, she will be worried”, reassure the resident “I will call her and tell her you are here with me.”~~
- ~~Assess for over tiredness. Provide for rest periods and naps during the day.~~
- ~~Assess for tobacco craving. Provide nicotine patch, gum, sugarless candy.~~
- ~~Assess for discomfort/pain. Provide analgesia for arthritis, etc.~~
- ~~Assess for hunger. Provide a snack.~~
- ~~Ask physician for a psych/ SATS consult.~~
- ~~Assess reside who are exit seeking, engage resident in activity~~
- ~~Relocate bed away from door or where more direct observation is possible.~~
- ~~Use Resident Locator System (RLS) and seat alarms.~~
- ~~Distract with planned group activities, 1 to 1 conversations, folding linens, helping staff carry items.~~
- ~~Help resident to develop a relationship with other residents, volunteers to decrease loneliness, to increase socialization on the unit.~~
- ~~Establish a time/routine for resident to make or receive phone calls from family and friends.~~
- ~~Display photos, letters, afghans and other personnel objects near resident’s bed.~~
- ~~If resident attempts to leave, remind resident that his family knows he is here and they would be disappointed and worried if he went somewhere else.~~

Adopted: 9/2006

Revised: 12/2007; 01/29/2013; 07/19/2015

Reviewed: ~~04/29/2013~~ 07/19/2015

Approved: ~~01/29/2013~~ \_\_\_\_\_

## Nursing Assessment for Behavioral Risk

ADDRESSOGRAPH

RISK FOR AGGRESSIVE BEHAVIORS DIRECTED AT OTHERS				
History of aggressive behaviors in the past year	YES	NO	Does the resident need a care plan for managing aggressive behaviors? YES NO If any of the questions were answered yes and you decided not to care plan, provide an explanation here.	
Increased signs of frustration, anger	YES	NO		
Increased psychomotor activity like pacing, rocking	YES	NO		
Threats of aggression (verbal or gestural)	YES	NO		
Clenched fists or jaws, tightening of muscles	YES	NO		
Throwing or destroying property	YES	NO		
Inappropriate attention to vulnerable residents	YES	NO		
Intolerance of others who are pacing, talking, intrusive.	YES	NO		
Other:				
RISK FOR BEING A TARGET FOR AGGRESSION				
History of victimization in the past year	YES	NO	Does the resident need a care plan for protection from being a target of aggressive behaviors? YES NO If any of the questions were answered yes and you decided not to care plan, provide an explanation here.	
Invades other people's physical space	YES	NO		
Handles belongings of others without permission	YES	NO		
Intrusive; interrupts the conversations or activities of others	YES	NO		
Loud and repetitive vocalizations and requests	YES	NO		
Unable to advocate for self (physically or cognitively)	YES	NO		
Other:				
ELOPEMENT RISK in a <u>cognitively impaired</u> person who is unable to make safe decisions outside the hospital. (May include those whose judgement is impaired by delusions.)				
Does the MD order indicate the resident is to be considered MCI?	YES	NO	If the answer is yes, continue with the assessment, If the answer is no, stop here	
History of elopement or attempts in the last six months	YES	NO	Does the resident need a care plan to prevent elopement? YES NO If any of the questions were answered yes and you decided not to care plan, provide an explanation here.	
Asking for money, asking directions, packing bags	YES	NO		
Watching the door / exit seeking	YES	NO		
Speaking about leaving/wanting to go home	YES	NO		
Expressing loneliness for family, friends	YES	NO		
Expresses dissatisfaction with facilities, services presently being provided	YES	NO		
Environment has changed / increased access to exits	YES	NO		
Other:				

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

1. Timeliness

- An assessment for behavioral risks is completed within 2 weeks of the completion of a comprehensive MDS, i.e., on admission, **quarterly**, significant change of condition, annually and when clinically indicated. It is also completed within 2 weeks of relocation. It is not necessary to do an assessment when completing a Medicare or a TAR MDS. **At the quarterly IDT meetings, document the review of Nursing Assessment for behavior risks that it is current and correct. If the IDT determines that there is a change, complete another form and revise care plan as needed.**

2. Instructions for completing the sections Risk for Aggressive Behaviors and Risk for Being a Target for Aggression

- Read each trigger question and circle YES if present or NO if it is not present.
- If the response to all the triggers is NO, there is no need to care plan or to give an explanation.
- If the response to one or more triggers is YES, initiate a care plan and inform the IDT;  
or,  
If you decide the resident is not at risk and you choose not to care plan, document your reasoning in the space provided.

3. Instructions for completing the Elopement Risk Assessment for residents who are unable to make safe decisions outside the hospital and have a MD determination of "Missing Cognitively Impaired" (MCI). This may include residents with delusions.

- This assessment is completed for only those residents who, because of their impairment, are unable to make safe decisions outside the hospital.
- Refer to the orders to learn if the physician determined that the resident is sufficiently impaired to be considered "Missing Cognitively Impaired."
- If the MD order does not indicate the resident is to be considered MCI, do not continue with the assessment.
- If the MD order indicates the resident is to be considered MCI, continue with the assessment.
- Read each trigger question and circle YES if present or NO if it is not present.
- If the response to all the triggers is NO, there is no need to care plan or to give an explanation.
- If the response to one or more triggers is YES, initiate a care plan and inform the IDT;  
or,  
If you decide the resident is not at risk and you choose not to care plan, document your reasoning in the space provided.

4. The Nursing Assessment for Behavioral Risks is part of the legal medical record.

- The completed assessment is kept behind the Nursing Admission Assessment in the Nursing Notes section of the Medical Record.
- The most recent 18 months of Nursing Assessments for Behavioral Risks will be kept in the open medical record.

**LICENSED NURSE WEEKLY BEHAVIOR SUMMARY**

ADDRESSOGRAPH

Month/Yr \_\_\_\_\_

- Summarize weekly behavior according to BMR .Do not use codes from Sections II III IV.
- Document all **observable side effects using code key below.**
- Use "CONT." for any baseline side effects that continue to be present.
- Compare weekly BMR results with behavior goal on care plan to determine **goal met/ not met.** Revise care plan goal PRN.  
 Primary Care Physician must be notified of this summary on a **monthly basis.**

<b>.Non Movement Side Effects:</b> <b>1. Anticholinergic Effects</b> Dry mouth, Blurry vision, Constipation, Urinary retention <b>2. Anxiety</b>  <b>3. Appetite Changes/Weight gain</b>  <b>4. Difficulty Sleeping//insomnia</b>  <b>5. Dizziness/Orthostatic Hypotension</b>  <b>6. Drowsiness</b>  <b>7. Head Ache</b>  <b>8. Heart Rate Changes</b> Tachycardia Bradycardia Arrhythmia <b>9. Increased Problem Behavior</b> Paradoxical Activation  <b>10. Disorientation/Confusion</b>  <b>11. Hypothermia</b>  <b>12. Difficult Urination</b>  <b>13. Seizures</b>  14. Other _____  <b>Movement Side Effects:</b> <b>15. Akathisia</b> Pacing, Motor restlessness, Sleep disturbance <b>16. Disturbed Gait</b> Increased Fall Risk <b>17. Dystonia</b> Muscle stiffness, Cramping, Neck stiffness <b>18. Tardive Dyskinesia</b> Involuntary movements, Abnormal tongue movements, Rocking <b>19. Other</b> _____	<b>Week</b> <b>1</b>	Write the Target Behavior Symptom/s:	Observations this week vs. last: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change	
	Triggers :			
	Interventions:	Outcome:		
	Side Effects Noted	Baseline?		
	Other:			
	<input type="checkbox"/> GOALS MET <input type="checkbox"/> GOALS NOT MET   Nurse Signature/Date			
	<b>Week</b> <b>2</b>	Target Behavior Symptom/s:	Observations this week vs. last: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change	
	Triggers :			
	Interventions:	Outcome:		
	Side Effects Noted	Baseline?		
	Other:			
	<input type="checkbox"/> GOALS MET <input type="checkbox"/> GOALS NOT MET   Nurse Signature/Date			
	<b>Week</b> <b>3</b>	Target Behavior Symptom/s:	Observations this week vs. last: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change	
	Triggers :			
Interventions:	Outcome:			
Side Effects Noted	Baseline?			
Other:				
<input type="checkbox"/> GOALS MET <input type="checkbox"/> GOALS NOT MET   Nurse Signature/Date				
<b>Week</b> <b>4</b>	Target Behavior Symptom/s:	Observations this week vs. last: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change		
Triggers :				
Interventions:	Outcome:			
Side Effects Noted	Baseline?			
Other:				
<input type="checkbox"/> GOALS MET <input type="checkbox"/> GOALS NOT MET   Nurse Signature/Date				

Primary Care Physician Notified via:    RCT Clip Board    Verbally   Date Notified: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name Legibly: \_\_\_\_\_

**LICENSED NURSE WEEKLY BEHAVIOR SUMMARY**

ADDRESSOGRAPH

(Additional week if needed)

<b>Week</b> 5	Target Behavior Symptom/s:	Observations this week vs. last: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change
Triggers :		
Interventions:		Outcome:
Side Effects Noted		Baseline?
OTHER:		
<input type="checkbox"/> GOALS MET <input type="checkbox"/> GOALS NOT MET		Nurse Signature/Date

**Rapid development of tolerance /dependence/ withdrawal symptoms –  
Taper Gradually**

Drug Class	Brand	Generic	Common Side Effects to Observe
<b>ANTI PSYCHOTICS</b> To reduce psychotic symptoms in schizophrenia and mania aggression or other problem behaviors in those with dementia  <b>Gradual Dose Reduction (GDR) must be attempted at least yearly or justified when not appropriate</b>	Risperdal Seroquel Zyprexa Haldol Clorzaril Thorazine	Risperdone Quietapine Olanzapine Haloperidol Clozapine Chlorpromazine	<b>Dystonia</b> - Abnormalities of muscle tone <b>Akathisia</b> - Restlessness or difficulty holding still <b>Anticholinergic</b> - Dry mouth, tachycardia, blurry vision, constipation urinary retention <b>Increased Sedation</b> <b>Neuroleptic Malignant Syndrome (NMS)</b> <b>Pseudo Parkinsonian</b> - cogwheel rigidity bradykinesia, drooling, tremors <b>Weight Gain/Increased Weight Gain</b> <b>Orthostatic Hypotension- dizziness</b> <b>Tardive Dyskinesia (TD)</b> - abnormal movements <b>Cardiac Rhythm Effects</b> <b>Increased Confusion</b>
<b>ANXIOLYTICS</b> To temporarily reduce anxiety and symptoms associated with panic disorders. Also used for delirium dementia and other cognitive disorders.	Xanax Klonopin Ativan Valium	Alprazolam Clonazepam Lorazepam Diazepam	<b>Slurred Speech</b> <b>Poor Judgment</b> <b>Uncertain Reflexes</b> <b>Excessive Sedation</b> - sleepiness, lethargy <b>Cognitive Impairment</b> - difficulty thinking <b>Increased Confusion</b> <b>Motor Instability /Fall Risk</b> <b>Weight Gain / Increased Weight Gain</b> <b>Orthostatic Hypotension- dizziness – falls risk</b>
<b>HYPNOTICS</b> For short term relief of insomnia.	Benadryl Atarax Restoril Halcion	Diphenhydramine Hydroxyzine Temazepam Triazolam	
<b>ANTIDEPRESSANTS</b> <ul style="list-style-type: none"> <li>• Tricyclic Antidepressants</li> <li>• SSR Is</li> <li>• Dopamine Reuptake Blocking Agents</li> <li>• S/NRIs</li> <li>• 5ht receptor Antagonists</li> </ul>	_____ Celexa Lexapro Wellbutrin Zoloft _____ Remeron	Amitriptyline Citalopram Escitalopram Bupropion Sertraline Trazadone Mirtazapine	<b>Dystonia</b> - Abnormalities of muscle tone <b>Akathisia</b> - restlessness or difficulty holding still <b>Anticholinergic</b> - Dry mouth, tachycardia, blurry vision, constipation urinary retention <b>Excessive Sedation</b> -sleepiness, lethargy <b>Insomnia</b> <b>Weight Gain/Increased Weight Gain</b> <b>Orthostatic Hypotension- dizziness</b>
<b>MOOD STABILIZERS/ ANTICONVULSANTS</b> To stabilize mood in bipolar disorders & prevention of seizures as well as management of chronic pain	Tegretol Depakote Lamictal Lithobid Stavzor	Carbamazepine Divolprex Lamotrigine Lithium Valproic Acid	<b>Pseudo Parkinsonian</b> - cogwheel rigidity bradykinesia, drooling, tremors <b>Steven Johnson Syndrome</b> - fever rash sore throat fatigue <b>Increased Confusion</b> <b>Orthostatic Hypotension- dizziness</b> <b>Increased agitation</b> <b>Headache</b>



## BEHAVIORAL MONITORING RECORD

ADDRESSOGRAPH

Month/Yr \_\_\_\_\_

### INSTRUCTIONS:

- Monitor and document behavior per shift
- **Section I:** Obtain the **Target Behavior Symptom** from the RCP or MD order
- **Section II, III, IV:** Correspond to the columns atop of chart. **Target Behavior, Trigger, Intervention/Outcome**
- Mark **O** when no behaviors are observed for the shift
- **Total number of shifts** with noted behavior is calculated at the end of **each month**.
- Legibly **PRINT** name next to Initials to ensure accountability

SECTION I: TARGET BEHAVIOR SYMPTOMS	Date	Nurse's Initials			I Target Behavior			II Triggers			III Interventions / IV Outcome		
		AM	DAY	PM	AM	DAY	PM	AM	DAY	PM	AM	DAY	PM
AA _____	1												
BB _____	2												
CC _____	3												
DD _____	4												
<b>SECTION II: TRIGGERS</b>	5												
1. Acute Infection	6												
2. Blood Glucose	7												
3. Change in Medications	8												
4. Constipation	9												
5. Fatigue/Poor Sleep	10												
6. Hunger/Thirst	11												
7. Toileting	12												
8. Pain	13												
9. Wet/Soiled Briefs	14												
10 ADL Needs /Bathing, Peri Care	15												
11 Boredom	16												
12 Excessive Noise/Stimuli													
13 Family Relations													
14 Interactions w/ Others													
15 Sensory Isolation (Glasses, Hearing aides)													
16 Staff Interaction													
17 Uncomfortable Clothes/Shoes													
18 Unknown													
19 Other:													
<b>SECTION III: INTERVENTIONS</b>	9												
A Encourage sleep	10												
B Offer food/drink	11												
C Offer pain meds	12												
D Reposition	13												
E Cold/Hot Pack	14												
F Balm	15												
G Offer other Meds	16												
H Contenance Care													
I Adjust Clothing Shoes													
J Adjust Temperature													
K Attend to sensory deficit- (Glasses, hearing aids, etc.)													
L One to One time													
M Activity													
N Reduce noise /stimuli													
O Redirect													
P Return to Room													
Q Other:													
<b>SECTION IV: OUTCOMES</b>	15												
+ Intervention was successful	16												
O No behavior change													
- Intervention was not successful													



# BEHAVIORAL MONITORING RECORD

ADDRESSOGRAPH

SECTION I: TARGET BEHAVIOR SYMPTOMS	Date	Nurse's Initials			I Target Behavior			II Triggers			III Interventions / IV Outcome		
		AM	DAY	PM	AM	DAY	PM	AM	DAY	PM	AM	DAY	PM
AA _____	17												
BB _____	18												
CC _____	19												
DD _____	20												
<b>SECTION II: TRIGGERS</b>	21												
1. Acute Infection	22												
2. Blood Glucose	23												
3. Change in Medications	24												
4. Constipation	25												
5. Fatigue/Poor Sleep	26												
6. Hunger/Thirst	27												
7. Toileting	28												
8. Pain	29												
9. Wet/Soiled Briefs	30												
10 ADL Needs /Bathing, Peri Care	31												
11 Boredom													
12 Excessive Noise/Stimuli													
13 Family Relations													
14 Interactions w/ Others													
15 Sensory Isolation (Glasses, Hearing aides)													
16 Staff Interaction													
17 Uncomfortable Clothes/Shoes													
18 Unknown													
19 Other:													
<b>SECTION III: INTERVENTIONS</b>													
A Encourage sleep													
B Offer food/drink													
C Offer pain meds													
D Reposition													
E Cold/Hot Pack													
F Balm													
G Offer other Meds													
H Contenance Care													
I Adjust Clothing Shoes													
J Adjust Temperature													
K Attend to sensory deficit (Glasses, hearing aids, etc.)													
L One to One time													
M Activity													
N Reduce noise /stimuli													
O Redirect													
P Return to Room													
Q Other:													
<b>SECTION IV: OUTCOMES</b>													
+ Intervention was successful													
o No behavior change													
- Intervention was not successful													
		Total Number of shifts with observed resident behaviors:											

Initials	PRINT Name legibly	Initials	PRINT Name legibly

## **MONITORING BEHAVIOR AND THE EFFECTS OF PSYCHOACTIVE MEDICATIONS**

### **POLICY:**

1. The Behavioral Monitoring Record (BMR; form MR330) will be used for each resident who receives psychoactive medication(s).

~~1.2.~~ The nurse is responsible for monitoring the effects of all psychoactive medication to evaluate if the medication is having:

- a. the desired effect on the target symptoms, and
- b. if adverse effects are present.

~~2. A Behavioral Monitoring Record (BMR) (form MR330) will be used for each resident who receives psychoactive medication(s). The nurse will~~ review the BMR and compare it to the goals of Nursing Care Plan to assess whether the goals of target symptoms have been met or not met.

3.

~~Every shift:~~

- ~~a. All staff will observe for presence of target behavior (s) and side effect (s) and report to the licensed nurse if observed.~~
- ~~b. Licensed nurse will document target behavior (s) and/or side effect (s) IF observed on the BMR. If no target behavior (s) and/or side effect (s) is observed, the expected documentation is weekly.~~

~~Weekly:~~

- ~~a. The nurse will summarize the BMR for the presence or absence of target behavior (s) and side effect (s) and document summary on "Log Sheet" section.~~

4. Psychoactive Medication care plans should state "Chart in BMR if behavior exhibited" and "Chart in BMR if side effects are noted".

5. The Daily Nursing Care Record (DNCR; form MR 343) will be used to monitor the effectiveness of medications prescribed to induce sleep.

### **PURPOSE:**

1. To assess the effectiveness of the plan of care, including non-pharmacological interventions in the management of behavior, mood and to induce sleep.
2. To know and monitor for side effects of psychoactive medications.

---

### **BACKGROUND:**

All medications that are administered to restrain or control behavior or to treat a disordered thought process are to be considered psychoactive medications. These include medications used to treat anxiety, depression, mania, schizophrenia, psychosis or to induce sleep. Refer to MSPP D01-05 Psychoactive Medications.

Psychoactive medications, unless clinically indicated and clearly documented, will be gradually reduced to the smallest possible dose necessary to manage the resident's behavior or medical condition.

**PROCEDURE:**

**A. Preparing the Behavioral Monitoring Record**

1. A current BMR will be kept in the Medication Administration Record (MAR) binder.
2. The licensed nurse and/or unit clerk, when transcribing an order for a new psychoactive medication or a medication with a new indication, will ensure that the drug is ordered and the pertinent diagnoses and target behavior symptoms are listed in the BMR.

**B. Monitoring and documenting behaviors ~~for all medications (other than sleep inducing medications)~~ using BMR**

1. All staff will observe every shift for presence of target behavior (and/or side effects and report to the licensed nurse if observed).
2. The Licensed Nurse will use the BMR to document target behavior(s) triggers, interventions and outcomes for the behavior. If observed on the BMR. If no target behavior observed during the shift, the licensed nurse will mark as zero.
3. Documenting target behavior(s) in the BMR:
  - a. The nurse initials the area of the BMR corresponding with the appropriate date and shift.
  - b. Using the Blank lines in Section I beginning with AA, the target symptom is coded and observed for throughout the shift and mark only when observed.
  - c. The nurse, whenever possible, uses the codes to identify the trigger, in Section II.
  - d. The nurse codes the intervention(s) that were used to manage the behavior in Section III.
  - e. The outcome of the intervention is coded in Section IV.
  - f. The nurse records the behavior once during the shift regardless of whether behavior occurs several times during a shift.
  - g. The nurse must document at least monthly for problem behaviors that are frequent but stable and well-managed.
  - h. The nurse collaborates with the CNA/ Patient Care Assistant (PCA) and other members of the Resident Care Team (RCT) to identify and document the status of target behavior symptoms, interventions and their effectiveness.
4. The licensed nurse will summarize the BMR for the presence or absence of target behavior(s) and side effects on the Licensed Nurse Weekly Behavior Summary in the Integrated Progress Notes section of the chart.
5. At least monthly, a summary of Behavioral Monitoring Record must be conveyed to the MD.
- ~~1. The nurse codes the behavior, indicating the intensity and the date and time the behavior occurred in section I.~~
- ~~2. The nurse, whenever possible, identifies the trigger(s) and completes the trigger section II.~~

- ~~3. The nurse codes the intervention(s) that were used to manage the behavior in section III.~~
- ~~4. The outcome of the intervention is coded in section IV.~~
- ~~5. If a behavior occurs several times during a shift, the nurse may code it once and in the comment section document the approximate number of times and provide information about the interventions tried. If the behavior is very pervasive, the nurse may document in the comment section when the behavior does not occur.~~
- ~~6. For problem behaviors that are frequent but stable, well-managed and reduced to the minimum possible, the nurse must document at least monthly.~~
- ~~7. The nurse collaborates with the CNA/ Patient Care Assistant (PCA) and other members of the Resident Care Team (RCT) to identify and document the status of target behavior symptoms, interventions and their effectiveness.~~
- ~~8. On the date that the nurse writes a weekly or monthly nursing summary, he or she reviews the BMR and writes a brief statement in section VI referring the reader to the nursing summary in the medical record.~~
- ~~9. At least monthly, a summary of Behavioral Monitoring Record must be conveyed to the MD.~~

**C. Monitoring and documenting presence of side effects ~~and documenting their presence~~**

- ~~1. The nurse will identify and observe the resident for known common medication side effects. The nurse will observe the resident for known common medication side effects.~~
- ~~2. The nurse will write a progress note describing the side effects and the follow up nursing interventions. Side effects will be recorded in section V of the BMR and the physician will be informed if they are new or worsening.~~
- 2-3. For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the nursing summary.
- ~~3. The nurse will write a progress note describing the side effects and the follow up nursing measures.~~
- ~~4. For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect, on the same date the nursing summary is written.~~

**D. Monitoring the effectiveness of medications used to induce sleep**

1. The CNA / PCA monitors the number of hours that a resident is awake on the DNCR.
2. The licensed nurse reviews the DNCR and assesses the effectiveness of medications used to induce sleep.
3. Licensed Nurse can initiate use of BMR for indication of interventions tried before giving medications.

4. As part of the weekly or monthly nursing summary, the nurse writes a summary statement about the quality and quantity of the resident's sleep.

**CROSS REFERENCES:**

[LHHPP 25-10 Use of Psychoactive Medication](#)

NPP C 3.0 Guidelines for Documentation of Resident ~~Status~~/Care by Licensed Nurses

NPP C 3.21 ~~Guidelines for~~ Documentation of Resident Care ~~by Certified Nursing~~ ~~by Nursing~~  
Assistant ~~or Patient~~  
~~Care Assistant~~

NPP J 1.0 Medication Administration

~~NPP J 2.0 Consent for Psychoactive Medications~~

MSPP D01-05 Psychoactive Medications

[MR 330 Behavioral Monitoring Record](#)

Document originated: 6/2006

Revised: 10/2010; 01/29/2013; ~~09/08/07/19/2015~~

Reviewed: ~~01/29/2013~~

Approved: ~~01/29/2013~~

## **GUIDELINES FOR DOCUMENTATION OF RESIDENT CARE by the LICENSED NURSE**

### **POLICY:**

1. The licensed nursing personnel who assess the resident's health status, and administer or supervise nursing care are responsible for writing progress notes and updating nursing interventions in the resident care plan.
2. Nursing progress notes are to be concise, accurate accounts of the resident's physical, emotional, spiritual and recreational status, progression or regression in functional capabilities or attainment of care plan goals and other changes in status. They are to reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.
3. NO LHH chart is to be sent to any other hospital. Photocopies of pertinent material will be sent with the resident, upon discharge, to another health facility.

### **PURPOSE:**

1. To guide Licensed Nurses in communicating relevant information regarding assessment, interventions, and outcomes to primary care providers to promote continuity and quality care for our residents.
  2. To maintain concise and accurate documentation.
- 

### **PROCEDURE:**

#### **A. Equipment**

Focused Progress Note Stamp and stamp pad

#### **B. General Charting Guidelines**

1. Write or print legibly on the proper forms in black ink, using the 24-hour clock.
2. Imprint resident name and information on each page of the medical record using the addressograph machine.
3. Each entry is to be signed at the time it is written with the nurse's first initial or first name, surname and license designation.
4. Restrict abbreviations to those listed on the approved LHH Abbreviations list.
5. Errors are to be corrected by drawing a single line through the error, printing "error" over the lined-out area and printing initials. No erasures or whiteout are to be made on any page of the medical record.
6. Don't generalize or use vague terms. Be specific in describing observations, physical findings or behavior. Give examples. Do not use the chart to accuse, blame or draw unfounded conclusions. Prejudging or labeling can impair resident care and caregiver integrity.

7. Notify Admissions and Eligibility when changes in the names, addresses or phone numbers shown on the face sheet become known.
8. The following original forms are to remain in the active medical record. When a discharged resident is readmitted these particular forms are transferred into the new chart.
  - a. Chronological Record of Admission-Transfer/Relocation-Discharge
  - b. Tonometry and Immunization Record
  - c. Ophthalmologist and Optometrist progress notes
  - d. Advanced Directives Progress Notes, MR 702

### **C. Charting Guidelines for Interdisciplinary Progress Notes**

1. Licensed nurses are to use basic charting guidelines when writing progress notes.
2. Each nursing entry is to be identified by complete date for month, day, year, and time of the hour and minutes. Include signature with initial or first name, surname and title. When a Weekly or Monthly Summary is written, label entry as such.
3. Identify and describe a problem, the interventions used to resolve it and the resident's response (outcome). Indicate progression or regression of resident's condition and attainment of the goals stated on the care plan.
4. Chart in chronological order. Write on every line and fill in blank spaces by drawing a line to the end of each entry.
5. **Late Entry:** When an entry has been omitted and others have charted in the Interdisciplinary Progress Notes, a late entry may be written if the nurse can clearly recall pertinent information. Late notes will be written after the last charted progress note. There is to be no attempt to insert the late entry where it was omitted. Write the current date, time and the words "**Late Entry**" for the original date and time of the omission and the content of the late entry.
6. Ensure accuracy and continuity. Record important information about problems or high-risk situations as soon as possible after they occur.
7. Progress notes are to include notifications to physician, stating the date, time, name of physician, what the physician was notified about, the physician's response, what orders were carried out and the resident response to interventions.
8. Consistent documentation is required when a resident refuses treatment or nursing care, for discussions about consequences to health and safety, and negotiations with resident to solve differences.
9. The **Focused Progress Note (FPN)** is initiated when a resident condition or incident requiring focused assessment, immediate action, and follow-up is identified. It includes an accurate description of the event as it relates to the resident. Nursing is responsible for completing a description of the situation, performing and documenting an initial assessment, initiating notifications and immediate actions, modifying the care plan and facilitating prompt follow up. The FPN stamp is imprinted in the Interdisciplinary Progress Notes. It is dated, timed and signed, as are all progress notes.



10. When a resident reports a concern about hospital staff, lack of treatment, verbal or physical mistreatment, the charge nurse is to investigate immediately, notify the nursing supervisor, document the resident's statements and action taken in the nursing progress notes and send a Confidential Report of Unusual Occurrence form to the quality assurance mailbox.
11. Summaries may be written on any shift with input from the resident, family and nursing staff on each shift.

**12. Weekly Summary**

Weekly summaries will relate to the care plan and address all active problems, resident responses to care, and progress or lack of progress in reaching goals. Use form MR 352 and check weekly summary box.

**13. Monthly Summary**

- a. In progress notes the nurse will address each active care plan problem, progress or lack of it in reaching goals and any change in status from previous month.
- b. To be certain the RCP is up to date with new problems, the nurse will examine resident for physical findings related to their identified problem areas and speak with the resident about their progress, concerns, and goals.
- c. The nurse will review the Resident Care Plan as the essential aspect of data collection for the monthly summary. Other sources of written information include the graphic record, weight sheet, physician or other interdisciplinary progress notes, previous nurses' progress notes, medications and treatment record, and ADL Notes.
- d. The nurse will obtain verbal input from the CNAs or PCA and licensed staff assigned to care for the resident on each shift.
- e. If, at any time, the licensed nurse determines that approaches on the care plan are incomplete or ineffective, she/he is to make the appropriate changes to add new problems or delete resolved problems, discuss the rationale in the summary note and report changes to the nurse manager and IDT members affected.
- f. Use Form MR 352 and check the monthly summary box.

**REFERENCES:**

Health Information Services Universal Chart Order  
RAI/MDS Manual

**CROSS REFERENCES:**

NPP C 1.0 Admission and Readmission Procedure  
NPP C 1.2 Relocation Procedure  
NPP C 1.3 Discharge Procedure  
NPP C 3.0 Documentation of Resident Care by the Licensed Nurse  
NPP C 3.2 Documentation of Resident Care by Certified Nurse Assistants & Patient Care Assistants  
NPP C 4.0 Physician Notification of a Change in Resident Status  
NPP D 8.0 Post-Mortem Care

Adopted: 8/2002

New: 9/2009

DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR ANNUAL PHYSICAL INVENTORY COUNT

**Objective:** To implement procedures to ensure that the fiscal year-end physical inventory count is scheduled and performed in the Department of Pharmaceutical Services in accordance with Laguna Honda Accounting Policies and Procedures.

**Policy:** The physical inventory of the Department of Pharmaceutical Services will be conducted on an annual basis, on or about June 30<sup>th</sup>. The inventory will be conducted on a normal workday to eliminate any overtime and accounting will be notified as to the actual date it will be scheduled by the end of April. The Pharmacy department will use an outside professional inventory service.

**Procedures:**

- I. There are written policies and procedures for safe and effective distribution, control and use of medications to ensure an adequate and prompt supply of medications to residents.
  - A. The Pharmacy department maintains a supply of medications and chemicals sufficient for the needs of the hospital.
  - B. There is a Hospital Formulary that is approved by the Pharmacy and Therapeutics Committee. The pharmacy will initiate purchase orders according to the regulations of the City Purchasing Department in order to maintain an adequate supply of medication.
  - C. Medications received from suppliers are checked against the invoices for correctness and then stored in the pharmacy following recommendations of the U.S. Pharmacopeia and National Formulary and regulations of the DEA. The pharmaceuticals are checked in by a different staff member than the staff placing the order. Narcotics are checked in by a pharmacy technician and a pharmacist other than the ordering pharmacist. After the supply is checked against invoice a pharmacist supervisor signs the delivery invoice and sends the invoice to accounting for payment.
  - D. Pharmaceutical products shall not be dispensed after the expiration date on the manufacturer's container. The pharmacy completes expiration date inspection of the entire pharmacy stock every month and expired medications are either returned to the wholesaler, manufacturer or reverse distributor. See Pharm 03.01.00
  - E. The pharmacy department receives notifications of all drug recalls and will quarantine and segregate recalls from the rest of the stock until they are returned for credit in accordance to recall notice. See Pharm 02.04.00
  - F. Only pharmacists have access to the pharmacy and keys to the narcotic room. The pharmacy helper and technicians have electronic access to the pharmacy during working hours only. See Pharm 01.01.01

II. Inventory preparation

- A. The Pharmacist-in-Charge will look at prior year feedback and examine the Physical Inventory records to determine if there should be any modifications of the procedures.
- B. The Pharmacist-in-Charge will ensure that only items that are considered to be part of the inventory are labeled appropriately. Areas in the pharmacy to be counted will be labeled according to the Pharmacy Inventory Map (Attachment 1).
- C. The Pharmacist-in-Charge will run a report on items which are located in the supplemental drug room Omnicell (Automated Medication Dispensing Cabinet) to include in the inventory count.
- D. On the morning of the inventory, a report of the Automated packaging machine inventory will be run, which will be included in the inventory count.

III. Inventory Count Procedures

- A. When the outside Professional Inventory Service team members arrive, the Pharmacist-in-Charge will give a brief orientation and written count instructions and map of areas to be included in the inventory.
- B. A pharmacy staff member will be assigned to each team member from the Professional Inventory Service team to answer questions relating to pricing, units in a package, etc.
- C. The inventory team will use the NDC # for pricing all pharmaceutical items. The pricing will be provided by the distributor.
- D. The inventory team will provide count sheets after counting each area and will tape to area for spot checking.
- E. If differences are noted during spot checking, the inventory team will be instructed to do a re-count of the area. The Pharmacist-in-Charge will instruct the inventory team if there are any adjustments necessary before the final report is printed.
- F. Any items received on the Inventory count day from the distributor will not be put in to the pharmacy stock until after the inventory. Invoices of stock received on inventory day will be provided to accounting.
- G. A report from the pharmacy operating system with the medications dispensed on the day of the inventory will be provided to accounting.
- H. All valuations sheets, electronic files and other supporting documents will be sent to accounting within 5 business days of performing the physical inventory.

ADOPTED: 07/2015

REVIEWED:

REVISED:

**POLICY AND PROCEDURE FOR DRUG SUPPLY CHAIN SECURITY ACT (DSCSA) TRANSACTION DATA**

**BACKGROUND**

The DSCSA was signed into law on November 27, 2013. The aim of the DSCSA is to identify and trace certain prescription drugs as they are distributed within the United States and to improve the security of the drug supply chain to protect U.S. patients from unsafe, ineffective, and poor quality drugs. In effect July 1, 2015, dispensers are required to capture the product tracing information and maintain the data for not less than six years after the transaction occurs. Additionally, trading partners are required to provide the subsequent purchaser with product tracing information.

**PURPOSE:** To ensure compliance with the provisions of the DSCSA for the tracing of products through the pharmaceutical distribution supply chain.

**POLICY:** Laguna Honda Hospital Department of Pharmaceutical Services shall not accept ownership of a product unless the transaction history, transaction information and transaction statement are provided; shall provide transaction data to subsequent owners; and shall capture transaction information, history and statements ("3T data") as necessary and maintain such information for not less than six years after the transaction.

**PROCEDURE:**

1. Transaction information, transaction history and transaction statements are available from the wholesale distributor web portal (McKesson Connect for not less than six years after the transaction.
2. 3T data provided on the packing slips for products received from sources other than the wholesale distributor (e.g. dropship, direct from manufacturer) will be scanned and saved onto the shared drive. The naming convention will be: item description.yyyymmdd example varavax20150501
3. 3T data provided to dispensers via third party vendors will be downloaded and saved onto the shared drive with similar naming convention as noted above.
4. When lending a product to another institution not under common control, 3T data (including lot number) will be provided to the institution. In cases where 3T data cannot be provided to the institution at the time the product is transferred, 3T data will be forwarded to the institution the following business day in order to prevent delays in patient care.

ADOPTED: 7/2015  
REVISED:  
REVIEWED:

**LAGUNA HONDA HOSPITAL  
DEPARTMENT OF PHARMACEUTICAL SERVICES**

**05.01.00**

**POLICY AND PROCEDURE FOR FORMULARY  
AND NON-FORMULARY MEDICATION REQUESTS**

**Policy:**

The Pharmacy Department will maintain a Drug Formulary available via the Intranet.

**Purpose:**

To provide hospital staff with a current list of drugs and biologicals available from the pharmacy.

**Procedure:**

- I. The P & T Committee is responsible for approving drug products for addition to or deletion from the formulary.
  - A. Addition of Drugs:
    1. To initiate a formulary addition, the requesting physician fills out a "Request for Formulary Addition" form, which is available in the pharmacy.
    2. The completed form is forwarded to the Pharmacy for review.
    3. The request is forwarded to the P&T Committee for processing, setting a date for presentation and responding to the requesting physician.
    4. The P&T Chairman is responsible for preparing or assigning preparation of research materials for presentation to the P&T Committee for the consideration of the request at the first available meeting.
    5. The requesting physician is invited to the meeting, the drug is discussed, a decision is made, and the information is disseminated to the hospital staff.
  - B. Deletion of Drugs:
    1. To request a formulary deletion, the requesting physician should contact the chairman of the P&T Committee.

**Policy:**

The pharmacy will request physicians to fill out a NONFORMULARY REQUEST FORM whenever a non-formulary medication is ordered.

**Purpose:**

To ensure proper use of the formulary, and to provide documentation of non-formulary drug use.

**Procedure:**

1. Each order for a non-formulary medication must be accompanied by a NF request form. The form will be completed either by physician or by pharmacist on verbal instruction of the physician.
2. The pharmacy will consult with the prescriber for clarification of non-formulary requests, and suggest formulary alternatives when they are available.
3. In an emergency situation or when the pharmacy is not open, non-formulary medications will be dispensed before the NF form has been completed. The NF form must be completed within 24 hours.
4. The completed form will be reviewed for appropriateness, and will be filed in the Pharmacy Department.
5. A summary report will be included in the monthly pharmacy report to the P&T Committee. NF medications which are used frequently will be considered for formulary addition and for educational programs or studies.

New: 9/92

REVIEWED: 02/05dw, 01/08, 04/09, 2/10, 4/11, 5/12, 8/13, 8/14

REVISED: 8/15

**POLICY AND PROCEDURE FOR THERAPEUTIC INTERCHANGE AND GENERIC SUBSTITUTION****Policy:**

The Pharmacy and Therapeutics Committee shall determine drugs that may be therapeutically interchanged by the pharmacist without consultation with the physician. Generic substitution of bioequivalent drugs is permitted unless a written order by the physician specifies that the drug is to be dispensed as written.

**Purpose:** To provide timely, efficacious, and cost efficient pharmaceutical care services.

**Procedure:**

1. The Pharmacy and Therapeutics Committee shall review all pertinent literature and analyze the cost benefit relationship of drugs proposed for therapeutic interchange.
2. Upon determination of efficacy, safety and cost effectiveness, the Pharmacy and Therapeutics Committee shall approve the addition of the proposed drugs to the Laguna Honda Hospital Therapeutic Interchange List.
3. The Pharmacy and Therapeutics Committee may also remove drugs from the Therapeutic Interchange List at its discretion.
4. The Chairman of the Pharmacy and Therapeutics Committee and the Pharmacy Director shall communicate changes to the Therapeutic Interchange List to the Medical, Pharmacy, and Nursing staff of the Hospital.
5. Pharmacists may interchange drugs listed on the Therapeutic Interchange List without first consulting with the physician.
6. If required to assure clarity and decrease the possibility for medication error, the pharmacist shall document an order for the therapeutic interchange drug on the patient's chart.
7. Unless specifically prohibited by a written or electronic physician order, pharmacists may dispense bioequivalent generic medication.

NEW: 3/94 sk

Revised: 4/97, 6/99, 5/00dy, 8/01dy, 10/03dw, 2/15, 7/15

Reviewed: 02/06, 01/08, 04/09, 2/10, 4/11, 5/12, 8/13

**POLICY AND PROCEDURE FOR MEDICATION REGIMEN REVIEW**

**Policy:**

The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest, practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing, the attending physician, the medical director and if appropriate the administrator.

**Purpose:**

To ensure accurate and proper medication administration to residents.

**Procedure:**

- 1) A pharmacist reviews the medication regimen of each resident at least monthly.
  - a) A more frequent review may be deemed necessary, e.g., if the medication regimen is thought to contribute to an acute change in status or adverse consequence.
  - b) Upon admission a preliminary medication regimen review will be conducted and include a medication reconciliation. The review will be documented by an entry in the electronic health record indicating "Medication Reconciliation Completed" date and time stamped with the reviewing pharmacist's name.
- 2) In performing medication regimen reviews, the pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards, such as the American Society of Consultant Pharmacists (ASCP) Practice Standards, and clinical standards such as the Agency for Healthcare Research and Quality (AHRQ) Clinical Practice Guidelines and American Medical Directors Association (AMDA) Clinical Practice Guidelines.
- 3) The pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs); prescribers' orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following:
  - a) Physician's orders
    - i) Date written
    - ii) Clarity of orders



- b) Medication regimen
  - i) Evaluate for possible interactions, incompatibilities, or contraindications, improper dosing and frequency, or other pertinent medication therapy issues.
- c) Diagnosis
  - i) A written diagnosis, indication, or documented objective findings to support each medication order.
  - ii) Pharmacists shall require clarification of orders for medications prescribed for non-FDA approved uses unless the use is recognized as the community standard, accepted clinical practice or there is literature to support use.
- d) Charting
  - i) Compare medications charted to those prescribed, including completeness, dosage, frequency of administration, and route of administration.
- e) Administration
  - i) Pharmacy will conduct an Observation Pass as outlined in policy 03.01.02. Nursing preparation and administration of residents' medications will be observed. .
- f) Laboratory tests
  - i) Laboratory tests should be reviewed for frequency of ordering and possible interference with test results by a medication the resident is taking. Laboratory tests will also be reviewed for abnormal values.
  - ii) Lab tests to monitor the efficacy and/or toxicity of certain medications may be recommended to the physician.
- g) Nurses' Notes
  - i) Clarity and continuity of entries pertaining to regular special care will be assessed in order to obtain a quick insight into condition or of unusual personal characteristics of the resident.
  - ii) Special attention should be noted in regard to accuracy of "prn" entries.
- h) Resident's Current History Entry
  - i) Note the resident's present medical condition as observed by the physician.
- i) The reviewing pharmacist will note to the physician instances of medication incompatibility, duplication of orders, missing diagnoses, incomplete orders, reevaluation of therapy requests, and other pertinent issues.

- 4) Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the facility MRR database and reported to the prescriber, Medical Director and Director of Nursing.
  - a) Notification mode is dependent on severity of irregularity.
  - b) The pharmacist will contact the physician directly for problems requiring his/her immediate attention.
  - c) The reviewing pharmacist will date and sign the resident's chart after each review.
  - d) If a continuing irregularity is deemed to be clinically insignificant, or evidence of a valid clinical reason for rejecting the recommendation is provided, the pharmacist will reconsider whether to report the irregularity again or make a new recommendation.
- 5) Recommendations are acted upon and documented by the prescriber and or the facility staff.
  - a) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.
  - b) If there is potential for serious harm and the attending physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the pharmacist contacts the Medical Director and the Director of Nursing
  - c) The Director of Nursing or designated licensed nurse addresses and document recommendations that do not require a physician intervention, e.g., monitor blood pressure.
- 6) The pharmacist compiles and analyzes data collected during MRR and presents findings to the Pharmacy & Therapeutics Committee as a part of the facility continuous quality improvement (CQI) program.

New: 10/91

Revised: 6/99DY, 2/02DY, 04/07dw, 08/11, 8/15

REVIEWED: 02/05dw, 02/06, 01/08, 04/09, 5/12, 8/13, 8/14

## SCOPE OF PHYSICAL THERAPY SERVICES

### **POLICY:**

The Physical Therapy Department provides a wide range of services to enhance and facilitate the rehabilitation process.

### **PROCEDURE:**

Physical therapy services include, but are not limited to:

1. Providing the physician with an initial written evaluation of the patient's rehabilitation potential.
2. Applying muscle, nerve, joint, and functional ability tests.
3. Treating patients to relieve pain, and to develop or restore function.
4. Assisting patients to achieve and maintain maximum performance using physical means such as exercise, massage, heat, sound, water, light, ice, and electricity.
5. Providing therapeutic interventions that focus on posture, locomotion, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain, and functional abilities in daily living skills.
6. Providing assessment and training in locomotion, including, as, appropriate, use of orthotic, prosthetic, and assistive devices
7. Providing patient and family education, as appropriate, and providing training to family or care giver(s) on patient's needs and abilities before discharge.
8. Participating as ancillary or consultative members of the Patient Care Team (PCT) to assist with developing the Patient Care Plan.

### **ATTACHMENT:**

None

**References:**

Barclays California Code of Regulations, Title 22 § 70555(a)(4), § 72403

Most recent review: ~~14/08/22~~15/08/28  
Revised: 06/09/20, 10/10/2, ~~15/08/28~~  
Original Adoption: 99/08/23

## **SCOPE OF SPEECH THERAPY SERVICES**

### **POLICY:**

The Speech Pathology and Audiology Department provides a wide range of services to enhance and facilitate the rehabilitation process.

### **PROCEDURE:**

Speech Pathology and Audiology services include, but are not limited to, the following:

1. Diagnostic Evaluation
  - a. Examination of oral motor function
  - b. Assessment of voice production
  - c. Assessment of speech production
  - d. Assessment of language skills, both comprehension and expression
  - e. Assessment of cognitive-linguistic skills
  - f. Evaluation of swallowing
  - g. Assessment for augmentative communication systems
  - h. Testing of hearing acuity for speech reception and discrimination
  - i. Evaluation of patient's ability to use hearing aids
2. Therapy
  - a. Speech
  - b. Voice production
  - c. Language comprehension and expression
  - d. Language-related cognitive skills
  - e. Provision of augmentative communication systems
  - f. Swallowing
  - g. Hearing (including aural rehabilitation and hearing aid fitting)
3. Consultation with other members of the Patient Care Team (PCT) regarding strategies to facilitate improved function on the care Unit.

4. Provision of patient/family education and training, as needed.
5. Development of Restorative Care Programs — Level II, when indicated

**ATTACHMENT:**

None

**REFERENCE:**

Barclays California Code of Regulations, Title 22 § 70597(a)(4)

Most recent review: ~~13/08/22~~15/08/28

Revised: 15/08/28; 04/08/18

Original Adoption: 99/08/2

INTERDEPARTMENTAL POLICIES AND PROCEDURES

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7.19 Social Services Department: Burial and End of Life Care Arrangements

**Policy:** It is the policy of the Social Services Department to ascertain pre-need or burial arrangements of residents upon admission and if none are in place, to check in with residents on a quarterly basis to offer continued resources and assistance in end of life care planning.

**Purpose:** To document and maintain communication with key departments about burial plans that are in effect and should be followed per resident wishes.

**Procedure:**

1. Social Workers will document Religious Preferences and Funeral Plans if known in the Initial Psychosocial Assessment (MR 703). If no plans have been made, by default it will be designated as a Public Administrator referral. A copy of the MR 703 is sent to the Admissions and Eligibility worker who is assigned to the resident. If residents transfer to another Unit during the course of their stay, this information will be reviewed with the new Social worker upon hand-off of the case.
2. Education and resource materials will be provided to interested residents and family members about the process of funeral planning and burial and cremation services.
3. Social workers will check in with residents on a quarterly basis when doing spend-downs of funds to see if residents are willing to put aside monies for a pre-need burial trust. This information is communicated to the Admissions and Eligibility worker via a change of face sheet information. It is also to be relayed to Nursing manager or charge nurse to enter this information unto the nursing care plan.
4. If resident's condition is declining and no plans have been executed, special efforts will be made to discuss plans with residents with capacity, surrogate decision makers or conservators who have decision making powers.
5. Social workers will coordinate provision of spiritual support with the Spiritual Care Department and relay information about special religious/cultural preferences to the nursing manager/supervisor.
6. In the event of a resident expiration, the social worker will meet with the nurse manager/supervisor and Admissions and Eligibility Worker the next business working day, to clarify what funeral plans are in place, ascertain what monies are available in resident's trust account and determine the disposition of clothing and personal effects. The outcomes of this discussion will be documented in the progress notes by the social worker.

## **SCD SPIRITUAL CARE REFERRALS**

Laguna Honda Hospitalwide Policies and Procedures

### **SCD SPIRITUAL CARE REFERRALS**

**POLICY:** The Spiritual Care Department manages effectively a system of responding to spiritual care referrals from staff, residents, their loved ones and volunteers. A written referral form is available for regular spiritual care referrals – worship services, special religious observances, visitations and spirituality groups. In addition, contact information is available for weekday evenings and weekend spiritual care emergencies.

**PURPOSE:** A well-communicated system of spiritual care referrals facilitates timely responses to the needs of residents and their loved ones on their spiritual journeys for meaning, love, connection, comfort and hope.

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#### **PROCEDURES:**

1. A written Spiritual Care Referral Form is available on the LHH Intranet under the Spiritual Care Icon for purposes of making referrals for worship services, special religious observances, visitations and spirituality groups.
2. The Spiritual Care Coordinator (SCC) receives referral forms, reviews them for appropriate action, coordinates necessary resources to respond to requests and conducts quality assurance.
3. If further information is necessary, the SCC contacts the person making the referral and/or visits the person requesting the spiritual care service. Sometimes, it also is appropriate to consult with unit staff or resident family members.
4. Referrals can also be made over the phone by contacting the SCC. (phone: 4-3043, [415-759-3043](#), pager: [415-327-1675](#) or cell phone at 415-269-5512.
5. In the case of an urgent or emergency request during **evenings** and **weekends (or if you are unable to contact the Spiritual Care Coordinator during the week)**, please refer to the Emergency Contact Information found on the LHH Intranet page under the Spiritual Care Icon. (copy is attached)
6. The target response time by the SCC/CPC to non-urgent referrals is 24 hours, although the actual service may require more time to coordinate such as arranging for attendance at an upcoming worship service.
7. The target response time to first contact referral parties for urgent or emergency requests is one hour for weekdays and two hours for evenings and weekends.
8. The Spiritual Care Coordinator maintains a comprehensive Spiritual Care contact directory for purposes of fully meeting the diverse needs of residents, staff, loved ones and volunteers of many faiths, cultures, ethnicities and languages.

Revised: 15/08/26 (Year/Month/Day)

Original adoption: 2010/01/17



**LAGUNA HONDA HOSPITAL  
SPIRITUAL CARE REFERRAL FORM**

**Date** \_\_\_\_\_

**Resident** \_\_\_\_\_

**Unit** \_\_\_\_\_ **Bed #** \_\_\_\_\_

**Type of Referral (check appropriate box):**

- One-on-one pastoral care visit
  
- Religious service      Which one? \_\_\_\_\_  
   Day and Time? \_\_\_\_\_  
   Requires Transportation? \_\_\_\_\_
  
- Prayer, Communion, Anointing or Blessing in Unit      (Circle preference)
  
- Other      Identify \_\_\_\_\_

**Faith Tradition, If Any** \_\_\_\_\_

**Reason for Referral**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Special Considerations**  
\_\_\_\_\_  
\_\_\_\_\_

**Referred By** \_\_\_\_\_

**Department** \_\_\_\_\_ **Phone** \_\_\_\_\_

*Send this form to LHH Spiritual Care and maintain a copy for your records.  
If this request is urgent, call 4-3043 or pager 415-327-1675 or cell 415-269-5512..*

## Emergency Contact Information for Spiritual Care

**Updated on 8-2-2014 8-21-2015**

1. In the case of an urgent or emergency request such as the death or impending death of a resident: **Tuesday thru Saturday** between 8:30am and 5:00pm the referring party calls or pages the Spiritual Care Coordinator (cell phone: 415-269-5512 pager: 415-327-1675).

On **Sundays and Monday** from 8:30am to 5:00pm please call Sister Dolores Maguire at 415-548-0475).

On Monday from 10:00am to 6:30pm please call Rev. Malaena Nahmias at 650-339-5660 or 415-759-3022

2. In the evening hours or you are unable to contact any of the above please call the following parties in this order:

### **If the resident is a Roman Catholic Christian call in this order:**

- A. During the hours of 8:00am to 10:00pm call Father Te at cell phone at 415-200-9359. If Father Te can't come or you get no answer please call the Saint Brendon's Church 24 hour pager at 415-280-0280.
- B. Call St. Anne's 24 hour line at 415-208-0117.
- C. Call St. Cecilla's 24 hour line at 415-664-8483.
- D. Call Sister Dolores Maguire at 415-548-0475.
- E. If during the day you can call the following churches and ask if they can send a priest. St. Cecilla's at 415-664-8481; St. Anne's at 415-665-1600; St. Stephen's at 415-681-2444; St. Gabriel's at 415-731-6161.
- F. For **Spanish speaking priests** please call Father John Jimenez (415-240-8095).
- G. Call the Spiritual Care Coordinator at 415-269-5512.

### **If the resident is Orthodox Christian (Russian, Syrian, etc...) please call in this order:**

- A. Father James at 415-571-3539.
- B. Call the Spiritual Care Coordinator at 415-269-5512.

### **For Protestant Christian residents call in this order:**

- A. Call the Spiritual Care Coordinator at 415-269-5512.
- B. Call Rev. Stephen Barlett-Re at 415-271-9080.
- C. For Chinese speaking Protestant Christians please call Rev. So. at 650-872-2563 or 415-221-7115.

### **For Buddhist Residents (Cantonese, Mandarin or English speakers) please call in this order:**

- A. Call and text Binh Trinh at 415-533-8728. You can also reach Binh at 415-585-2797.
- B. Call the Spiritual Care Coordinator at 415-269-5512.

### **For Jewish Residents please call in this order:**

- A. Call Rabbi Nosson Potash 415-598-8718.
- B. Call the Jewish Healing Center at 415-750-4197.
- C. Call Rabbi Jon Sommer at 415-750-4198; Rabbi Naton Fenner at 415-750-4129; Rabbi Eric Weiss at 415-750-4199.
- D. Call the Spiritual Care Coordinator at 415-269-5512.

### **For Muslim Residents please call in this order:**

- A. Call Souleiman Ghali at office 415-863-7997 or cell at 415-215-8929.
- B. Abu Qadir Al-Amin at cell phone 415-424-8793.
- C. Call Spiritual Care Coordinator at 415-269-5512.

**For residents of no expressed faith but wish to speak with clergy please call the Spiritual Care Coordinator at 415-269-5512.**

## ~~ENCOURAGEMENT AND RETENTION~~ Recruitment PROCESS LIFE CYCLE Life Cycle

### **POLICY:**

~~Laguna Honda Hospital Volunteer Services~~ The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center shall take active steps to encourage, retain, and express appreciation for the existing LHH volunteers. ~~is responsible for the full recruitment process life cycle of hospital volunteers~~ business life cycle of volunteers, from initial registration for an orientation to placement in the hospital, including recruitment, placement, encouragement and retention, and dismissal.

### **PURPOSE:**

1. To outline formal steps involved in developing a general pool of volunteers available to the hospital.
2. To increase the length of stay, quality of work and enhance a positive attitude within the volunteer pool at Laguna Honda Hospital. meet the specific human resource needs of the department and organization. of hospital departments requesting the assistance of Volunteer Services Department.
- 4-3. To ensure that Laguna Honda Hospital hospital residents receive thereceive the highest quality volunteers to provide companionship and support. highest quality of care and support possible. define and

### **PROCEDURE:**

#### Volunteer Recruitment

1. Friends of Laguna Honda Website  
Friends of Laguna Honda
  - a. Inc., (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.
2. Outreach
  - a. The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.
  - b. When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.
3. Media

- a. The Volunteer Services Department and Friends of Laguna Honda may utilize Public Service Announcements written and electronic media for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.
4. Volunteer Organizations
  - a. The Volunteer Services Department maintains listings of volunteer opportunities at Laguna Honda Hospital with local community volunteer organizations such as the San Francisco Volunteer Center and Hands on Bay Area.

## **Volunteer Placement**

### **1. Orientation**

- a. Each prospective volunteer is required to participate in the volunteer orientation prior to placement.
- b. At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.
- c. Each volunteer is required to complete a volunteer application prior to the interview.

### **2. The Interview**

- a. Content of the interview may include:
  - i. Review information on the application
  - ii. Visual inspection of a picture ID
  - iii. Reasons and motivations for doing volunteer work
  - iv. Discussion of areas of interest and hospital placement need
  - v. Review abuse reporting policy and sign form
  - vi. Review volunteer agreement and sign form
  - vii. Review statement of privacy laws and acknowledgement of responsibility and sign form
  - viii. Arrangements for TB test, ID badge, and parking permit
  - ix. Criminal background check and fingerprinting
- b. During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.
- c. The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department of where he/she will volunteer in.
- d. The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.
- e. A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.

### **3. Placement**

- a. The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident

- involved.
  - b. Volunteers are assigned a supervising staff member from the department in which they are placed. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators assumes responsibility for supervision of the volunteer.
  - c. The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) in the specific department he/she is interested in. The POC and the volunteer will then further discuss logistics (commitment, time, schedule, etc.) to finalize placement. Occasionally the Volunteer Coordinator may not be available at the proposed meeting time, and may arrange a meeting between the volunteer and supervising staff member.
  - d. Number of hours per week or month is negotiated between the volunteer and the supervising staff member in consideration of the needs of the activity, neighborhood, resident, and the availability of the volunteer.
  - e. The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes.
  - f. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).
4. The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.

### Encouragement and Retention

- ~~—The Volunteer Services Department, in conjunction with “Friends of Laguna Honda”~~
- ~~1. (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), undertake~~ actions during the annual National Volunteer Week in April to express appreciation toward all volunteers.
- 2.1.
- a. These actions may include an appreciation luncheon/dinner or other similar event.
  - b. Banners or posters will be displayed throughout the hospital recognizing National Volunteer Week.

~~3.~~ The appreciation Luncheon/dinner will recognize volunteers for the number of cumulative hours served, and the number of years given in service.

~~4.2.~~

a. Certificates will be awarded with the total number of volunteer hours as of April 1st. These certificates are signed by the president of Friends of Laguna Honda.

b. Service pins are awarded to Volunteers with the following years of service:

- i. Five years
- ii. Ten years
- iii. Fifteen years
- iv. Twenty years

~~v.~~ And so on in increments of 5 years

~~vi-v.~~

~~5.~~ Volunteers who are on duty during the day lunch are entitled to a 50% discount at the hospital's cafeteria for one meal during their shift.

~~6.3.~~

a. Volunteers must show their volunteer identification badge to the cashier to receive the discount.

~~7.4.~~ Thank You Cards will be sent to individual volunteers to recognize those who help above and beyond the call of duty (i.e., special events volunteers, special projects, Holiday Program and Gift Shop and Community Outing ~~those volunteers~~ who come in on days they are not scheduled, Holiday Gifts ~~volunteers~~).

~~8.5.~~ Volunteer Coordinators will make an effort to respond to volunteer questions, concerns or needs in a timely manner.

## ~~Volunteer Recruitment~~

### ~~1. Friends of Laguna Honda Inc. Website~~

~~Friends of Laguna Honda Inc. maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.~~

### ~~2. Outreach~~

~~The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.~~

### ~~3. Media~~

~~The Volunteer Services Department and Friends of Laguna Honda may utilize Public Service Announcements written and electronic media for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.~~

#### 4. Volunteer Organizations

~~The Volunteer Services Department maintains listings of volunteer opportunities at Laguna Honda Hospital with local community volunteer organizations such as the San Francisco Volunteer Center and Hands on Bay Area.~~

#### 5. Targeted Outreach

~~When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.~~

### Volunteer Placement –

- ~~— Each prospective volunteer is required to participate in the volunteer orientation prior to placement.~~
- ~~— At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.~~
- ~~— Each volunteer is required to complete a volunteer application prior to the interview.~~
- ~~— The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.~~
- ~~— The Interview~~
  - ~~a. Content of the interview may include:~~
    - ~~—— Review information on the application~~
    - ~~—— Visual inspection of a picture ID~~
    - ~~—— Reasons and motivations for doing volunteer work~~
    - ~~—— Discussion of areas of interest and hospital placement needs~~
    - ~~—— Review abuse reporting policy and sign form~~
    - ~~—— Review volunteer agreement and sign form~~
    - ~~—— Review statement of privacy laws and acknowledgement of responsibility and sign form~~
    - ~~—— Arrangements for TB test, ID badge, and parking permit~~
    - ~~—— Criminal background check and fingerprinting~~
  - ~~—— During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.~~

- ~~— The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department of where he/she will volunteer in.~~
- ~~— The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.~~
- ~~— A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.~~

#### 6. Placement

- ~~— The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident involved.~~
- ~~— Volunteers are assigned a supervising staff member from the department in which they are placed. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators assumes responsibility for supervision of the volunteer.~~
- ~~— The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) in the specific department he/she is interested in. The POC and the volunteer will then further discuss logistics (commitment, time, schedule, etc.) to finalize placement. Occasionally the Volunteer Coordinator may not be available at the proposed meeting time, and may arrange a meeting between the volunteer and supervising staff member.~~
- ~~— Number of hours per week or month is negotiated between the volunteer and the supervising staff member in consideration of the needs of the activity, neighborhood, resident, and the availability of the volunteer.~~
- ~~— The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).~~

#### Volunteer Dismissal

The procedure for disciplinary action is a three step process which includes:

1. The procedure for disciplinary action is a three step process.

1. a. First a formal written notice is sent to the volunteer.

2. b.



~~2.~~ Second formal notice is sent and a meeting with the volunteer, their supervisor  
\_\_\_\_\_ -from the area they volunteer and the Volunteer Coordinator is set up.

~~3.~~ 6.

~~3.~~ Notice to the volunteer of dismissal of their duties. The volunteer will be  
— responsible to turn in their ID Badge and a Parking permit if they might have one.

— Conduct or behavior which may lead to disciplinary action includes, but is not  
limited

~~4.~~ to:

- Poor Timekeeping and or unreliability of their time.
- Not following rules, policies as described in the Orientation Packet
- Rudeness or hostility towards, residents, staff or other volunteers.
- Intoxication through alcohol or other illegal substances
- Theft of property or compensation for assisting residents
- Failure to perform volunteer duties as agreed
- Bringing illegal substances in to the hospital

**ATTACHMENT:**

None

**REFERENCE:**

None

Revised: 2015/20/03, 2015/08/19

Original Adoption: 1998/06/01

## **VOLUNTEER FINGERPRINTING**

### **POLICY:**

The Volunteer Services Department will have all potential volunteers undergo a background check with the Department of Human Resources (DHR).

### **PURPOSE:**

1. To meet the specific human resource needs of the department and the organization.
2. To ensure that LHH residents and staff receive the highest quality of care and safety.

### **PROCEDURE:**

1. The Volunteer Coordinator will coordinate an appointment (time and date) for the volunteer receive a background check through the online County of San Francisco, Department of Human Resources (DHR) Fingerprinting Link:  
[www.genbook.com/bookings/slot/reservation/30108158](http://www.genbook.com/bookings/slot/reservation/30108158)
2. The Volunteer Coordinator will then click onto the “fingerprinting” link followed by clicking “no preference” to schedule an appointment by selecting the month and day for the volunteer to undergo a fingerprint. The Volunteer Coordinator will also add the volunteer’s personal information (First name, Last name, contact phone, email address, Job Code, Appointment type, and the last 4 digits of the volunteer’s SSN). The Volunteer Coordinator contact number will be entered before confirming the appointment.
3. The Volunteer Coordinator will then inform the volunteer of the appointment and the address via email and verbally during the interview.
4. The Fingerprinting office is located at:  
One South Van Ness on the corner of Market and South Van Ness  
(back of Bank of America) 4<sup>th</sup> Floor,  
City & County Human Resources Department
5. The volunteer must be punctual for the background check appointment and must call the DHR (415-557-4976) a day ahead if cancelling the appointment.
6. The resulting report of the conviction history (if any) will be used to determine if a volunteer will be disqualified.

7. The Volunteer Services Department will consider many factors before disqualifying a volunteer based on the conviction or arrest such as:
  - a. Nature and gravity of the offense
  - b. Volunteer-relatedness of the offense
  - c. Time elapsed since the conviction or release from sentencing (Note: Convictions of murder, attempted murder, mayhem, an arson-related offense, or a sex offense requiring registry, will be considered regardless of time elapsed since conviction or release from sentencing)
  
8. If it is determined by the Volunteer Services Department that a volunteer is disqualified, he/ she will be contacted by a Volunteer Coordinator and be given other volunteer opportunities in other communities or organizations.

**ATTACHMENT:**

None

**REFERENCE:**

CCSF – DHR

Revised: 14/10/07

Original Adoption: 2015/10/07

## **VOLUNTEER ORIENTATION REGISTRATION**

### **POLICY:**

The Volunteer Services Department will register all prospective volunteers for an orientation via the Friends Of Laguna Honda website ([lagunahondavolunteers.org](http://lagunahondavolunteers.org)), via [email: volunteers@sfdph.org](mailto:volunteers@sfdph.org) or via telephone.

### **PURPOSE:**

To provide potential volunteers an opportunity to sign up for an orientation through various channels.

### **PROCEDURE:**

1. Volunteer Coordinators (VC) will be responsible to screen and review all incoming calls from the Volunteer lounge phone to register probable volunteers on a daily basis. The VC will also be assigned to check email to register future volunteers.
2. The Friends Of Laguna Honda website ([lagunahondavolunteer.org](http://lagunahondavolunteer.org)) is linked with the email address ([volunteers@sfdph.org](mailto:volunteers@sfdph.org)) therefore when a prospective volunteer signs up for an orientation through the website, it will automatically appear on the email.
3. The VC will enroll potential volunteers in the Orientation registration book (located in the Volunteer lounge) and will stop enrolling volunteers when there are 20 attendees for an orientation.
4. The VC will recommend other orientations as there are 2 orientations each month for prospects when enrollment has reached its maximum capacity.
5. The VC is responsible for calling and reminding volunteers of the orientation to confirm their attendance.

### **ATTACHMENT:**

None

### **REFERENCE:**

None

Most Recent Review:12/08/17

## INFECTION CONTROL

### POLICY:

The Volunteer Services Department will comply with infection control policies established by the Infection Control Committee and Medical Staff at LHH.

### PURPOSE:

To protect the health of residents, employees and their families, volunteers, and visitors by preventing the transmission of tuberculosis, influenza and other infectious diseases.

### PROCEDURE:

1. All volunteers receive instruction about infection control at the volunteer orientation.
  - a. Topics covered include:
    - i. Hand washing
    - ii. Standard precautions related to bodily fluids
    - iii. Staying away from LHH when a volunteer is ill.
2. All new volunteers are required to have a 2 step T.B. skin test (PPD) prior to beginning their volunteer service at the hospital.
  - a. Volunteers may get the Tuberculosis test at the Laguna Honda Medical Clinic or with their own provider.
  - b. If a volunteer has documentation of a prior PPD negative test that was completed within a year, it's considered valid.
3. When having TB testing administered at the Medical Clinic, the volunteer will examine skin for any visible reaction in approximately 48 – 72 hours after the test. If there is no reaction, the volunteer will return to the Medical Clinic the following week for a second test. The volunteer will then return within 48 – 72 hours (2 days) for a second reading. If ~~the~~ test is negative, the volunteer is cleared to begin their volunteer service.
4. If a volunteer has a positive reaction to the T.B. test, they will receive a chest x-ray (if they are a resident of San Francisco) at SFGH. If they are not a resident of San Francisco, he/ she will need to go to their county hospital or private physician. The results are ~~to be sent~~ to the Laguna Honda Hospital Medical Clinic along with ~~the~~ T.B. symptom questionnaire.
  1. Volunteers having a positive reaction who do not reside in San Francisco will be counseled to get follow up at their county health department. Those volunteers must

provide documentation that they do not have active T.B. before being allowed to begin volunteer work at Laguna Honda.

2. Any volunteer determined to have active T.B. are referred to the Department of Health of their county which they reside in for further advice/action.
3. All active volunteers will be required to receive an annual tuberculosis screening. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptom review for those with prior positive skin tests.
4. Documentation of all PPD tests will remain in the Medical Clinic. ~~Documentation of volunteers that are no longer active and are a year old will be discarded.~~ The clinic will maintain all volunteer documentation and create a spreadsheet of those that are still active and contact the Volunteer Services Department for those that are due for yearly testing.
5. Volunteers who fail to get an annual T.B. test will be contacted by Volunteer Services and not be allowed to return until he/she receives a T.B. test.
6. All volunteers are required to comply with the hospital's Influenza Vaccination policy on an annual basis.
  - a. Volunteers are required to get an influenza vaccination by the beginning of flu season as identified by the hospital's Infection Control Committee.
    - i. If available, volunteers are able to get the vaccinations at Medical Clinic.
    - ii. If there not available at the hospital, the volunteer must get a vaccination form their provider and submit proof of vacation to the Medical Clinic.
  - b. Volunteers who have received an influenza vaccination will be provided with a sticker to be placed on the ID badge which will allow them access to resident areas during flu season.
  - c. Volunteer choosing not to get an influenza vaccination must sign a declination form.
    - i. During the flu season, if a volunteer chooses not to get a vaccination, he/she must wear a mask when in a resident area or within 3 feet of a resident.

**ATTACHMENT:**

None

**REFERENCE:**

LHHPP 72-01 Infection Control Manual

LHHPP 72-05 Employee Vaccination Policy  
Volunteer Services policy A 1.0 Volunteer Orientation

Revised: 2014/06/09, 2015/08/19  
Original Adoption: 2012/08/14

## VOLUNTEER INJURY

### POLICY:

1. Volunteer Services will assist in the proper handling of an onsite injury sustained by an on duty Laguna Honda Hospital volunteer.
2. Volunteers are not Laguna Honda Hospital Employees, and are not covered by Workers' Compensation.

### PURPOSE:

1. To ensure that volunteers are treated according to protocol in the event of an injury while at Laguna Honda Hospital.
2. To prevent injuries to volunteers while at Laguna Honda Hospital.

### -PROCEDURE:

1. In the Event that a volunteer sustains an injury while performing assigned volunteer duties, the Volunteer Coordinator will be informed. The volunteer may contact the Volunteer Coordinator directly or she or he may report the injury to the assigned supervising staff member who would then contact the Volunteer Coordinator.
- ~~2.~~The Volunteer Coordinator is responsible for investigating the circumstances of the injury that may include interviewing the volunteer and any staff person, non-staff person, or resident involved.
- ~~3.~~ ~~The Volunteer will be offered a single initial evaluation and treatment of the injury at the OHS Clinic at SFGH (Bldg. 9, 2<sup>nd</sup> floor, 1001 Potrero Ave. SF, CA 94110, phone: 415-206-8998) if the injury occurs during normal business hours of the OHS clinic and the volunteer's arrival at the clinic before closing is feasible.~~
- ~~4.~~ ~~If the OHS clinic is not available, the volunteer will be offered a single evaluation and treatment at the SFGH Emergency room.~~
- ~~5.2.~~ ~~The cost of this medical evaluation will be absorbed by the Department of Public Health.~~
- ~~6.~~The Volunteer Coordinator will complete an Incident Investigation Report (attached) and will fax to: OSH 101 Grove Street, Room 217, 415-554-2562 within 24 hours of receiving the injury report.
- 3.
- 7.4. The Volunteer Coordinator will complete an Unusual Occurrence Report (attached) and forward to Quality Management, 415-759-3053, so that the situation can be investigated and any appropriate preventative measures implemented.



~~8.5.~~ If the volunteer is injured during a time that a Volunteer Coordinator is not on duty, the preceding actions will be the responsibility of the volunteers supervisor to call 911 and notify the Volunteer Coordinator and fill out an Unusual Occurrence Report

~~9.6.~~ All volunteers sign the Volunteer Agreement Checklist, which states that it is the responsibility of the volunteer to provide services for their injury through their own care provider.

**ATTACHMENT:**

None

**REFERENCE:**

None

Most recent review: 12/08/15

Revised: 12/08/15

Original adoption: 08/08/25

Revised 15/08/27

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## RECORD KEEPING

### POLICY:

Laguna Honda Hospital Volunteer Services maintains records of participating volunteers.

### PURPOSE:

To adequately record volunteer activity for recognition, operations improvement and volunteer references.

### PROCEDURE:

1. The Volunteer Services Department utilizes the Volgistics database system in managing volunteer records.
  - a. The Volunteer Services Department also maintains a binder with information form each active volunteer. The following information is maintained in the Activity Volunteer Binders.
    - i. Application form
    - ii. Adult Abuse Reporting Requirement form
    - iii. Volunteer Agreement/Checklist
    - iv. Volunteer Confidentiality form
2. Upon acceptance and placement within the volunteer program, the Volunteer Coordinator is responsible to ensure that the volunteer's information is entered into Volgistics including, but not limited to, assignment, schedule, and emergency contact information.
3. The Volunteer Coordinator is responsible to file all hard copy forms in the Active Volunteer Binders.
4. All volunteers are required to log onto Volgistics and the beginning of their shift and log out at the end of their shift using the kiosk located in the lobby of the pavilion building.
5. If the computer is not operational~~off line~~, volunteers are required to contact the Volunteer Coordinator by email or phone so that the Volunteer Coordinator can input the hours into the Volgistics database.
6. The Volunteer Services Department is able to generate reports from Volgistics to be used for recognition activities and productivity reports.

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7. Volunteers are required to notify the Volunteer Services Department when they plan to discontinue their volunteer service.
    - a. Records for volunteers who complete their service or who are separated are archived within Volgistics.
    - b. Hard copy files are removed from the binder and discarded appropriately.
  8. At the end of each month, a Volunteer Coordinator runs an inactivity report to identify volunteers who have not reported to their assignment over the preceding 3 months.
    - a. The Volunteer Coordinator makes a determination as to whether the records should be archived or to maintain the volunteer's active status.
  9. Volunteers who resume their service after a period of inactivity have their files restored within Volgistics by the Volunteer Coordinator.
    - a. The information is reviewed and up-dated as appropriate.
  10. Volunteers who resume their service after a period of inactivity must complete all applicable hard copy forms s which are filed in the Active Volunteer Binders.

**ATTACHMENT:**

None

**REFERENCE:**

None

Revised: 2014/06/09, 2015/08/19

Original Adoption: 1998/06/01

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## In-Kind Donations

### POLICY:

The Volunteer Services Department is routinely responsible for accepting and processing in-kind donations for the hospital.

~~Laguna Honda Hospital~~The hospital does not arrange for the pick up of donated items. The donors are responsible for getting donated items to the hospital.

### PURPOSE:

To process donations in an effective and efficient manner; to ensure that donations are allocated to appropriate areas.

### PROCEDURE:

1. In-kind donations are non-financial donations of items such as clothing, furniture, medical equipment, books, etc.
2. The Volunteer Services Department maintains a list of suggested donation items; as well as a list of items that can not be used at the hospital. The Volunteer Services Department makes the list of suggested donations available to a potential donor upon request. The dDepartment may also use the list of suggested donations to advertise or solicit for donations in support of resident programs.
3. Donations are accepted in front of the Volunteers Services Department, Monday through Friday, from 8:30AM to 5PM.
4. A Laguna Honda Hospital and Rehabilitation Center Gift Receipt Form is completed for all donations.
  - a. The donor may request an acknowledgement letter unless information is unknown.
5. Donations may be dropped off in front of the Volunteer Services Department even if staff are unavailable.
  - a. Gift Receipt forms are left in a prominent place with instruction to accommodate donors.
  - b. If donations are dropped off when Volunteer Services staff are unavailable and no Gift Receipt Form is completed by the donor, Volunteer Services staff document the donor as being "anonymous" on the form.
6. Acknowledgement letters are prepared by the Volunteer Services Department and signed by a Volunteer Coordinator and the Executive Administrator.

7. Completed Gift Receipt Forms are kept on file for three years.
8. The Volunteer Services Department provides the Finance Department with copies of all completed Gift Receipt forms on a quarterly basis for donations received as of the last day of January, April, July, and October, of each year.
9. A Volunteer Services staff or volunteers are responsible for processing or distributing donations. Donated items evaluated to be inappropriate for use within the hospital will be donated to other community organizations.
  - a. Clothing and Shoes
    - i. Are taken to the Clothing Room for processing.
    - ii. Must be in good, clean condition.
    - iii. Larger sizes in men's and women's clothing are preferred.
    - iv. Practical and functional clothing and shoes will be stored in the Clothing Room and distributed to residents per Clothing Room Policies and Procedures.
  - b. Books are evaluated for appropriateness and are either taken to the Resident Library, recycled or to another organization with a need.
  - c. Medical Equipment
    - i. Medical supplies and food items are not accepted (i.e., bandages, gauze, Ensure or any other supplemental drink.)
    - ii. LHH does not accept beds, prescription drugs, diapers, syringes, tubing and commodes.
    - iii. Durable medical equipment accepted include but are not limited to: manual wheelchairs, electric wheelchairs, canes, crutches and other assisted devices.
    - iv. The equipment must be clean and in good condition.
    - v. Upon receipt of donated medical equipment, the Volunteer Services Department will contact Rehabilitation Services to evaluate equipment for appropriateness.
    - vi. Central Supply does not accept donated medical products (and miscellaneous equipment) due to quality control issues.
    - vii. Any equipment deemed inappropriate by Rehabilitation Services will either be disposed of or donated to another community organization.
    - ~~viii. Community organizations who accept medical equipment include:~~
      - ~~• Foundation for Sustainable Development at 415-283-4873~~
      - ~~• Home Care at 415-487-5405~~

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## 10. Food

- a. Due to food safety concerns, food items are generally not accepted as a donation.
- b. All donated foods must be from a commercial source, which may be accepted at the discretion of the Volunteer Services Department.

11. Miscellaneous items are distributed to resident neighborhoods, the Activity Therapy Department or used as holiday gifts.

## 12. Desired for donation

- a. *Women*: housecoat, costume jewelry, lipstick, lotion, nightgown, perfume, knee-high socks.
- b. *Men*: electric razor, shirt, wallet, cologne, after shave
- c. *Unisex*: pajama, hat and scarf set, bathrobe, stationery, stamps, pen, booties with soft soles, bedside clock, radio, camera, wrist watch, cardigan, sweater, afghans (lap robes) 40" x 40" or larger.
- d. *Other Items*: bulbs and seedlings, flowers, small plant, foreign language dictionaries, large print books, music compact discs paperback books, books on tape and headphones, reference books, picture calendars, playing cards, greeting cards, games for adults (dominos, chess, checkers).
- e. Magazine subscriptions such as Ebony, Jet, Smithsonian, Games, Crossword Puzzles, People, Playboy, Inquirer, Star, Esquire, Sierra Club, Wilderness, Pacific Discovery, Reader's Digest (large print), foreign language (Russian, Italian, Spanish, Chinese, Japanese, French)
  - Subscriptions are mailed to:

Resident Library  
Laguna Honda Hospital  
375 Laguna Honda Blvd.  
San Francisco, Ca. 94116

### **ATTACHMENT:**

None

### **REFERENCE:**

LHHPP 85-03 Donations

Most recent review and revision: 15/01/06

Revised: 12/05/21, ~~15-0/808/19~~

Original Adoption: 98/06/01

## **CLOTHING ROOM**

### **POLICY:**

Laguna Honda Hospital (LHH) will provide a process for distribution of clothing and to residents.

### **PURPOSE:**

To provide clothing for the needs of the residents of LHH.

### **PROCEDURE:**

1. The Clothing Room is under the management of the Volunteer Services Department and is staffed by LHH volunteers.

2. All clothing brought to the Clothing Room is either donated or recycled from resident units. Clothing is sorted, cleaned if necessary, and organized for selection by LHH volunteers or staff.

3. Any clothing determined to be inappropriate is donated to other community organizations.

4. Residents must be accompanied by a staff member or unit volunteer, or provide a signed clothing room form from unit staff to receive clothing, which must indicate the items needed.

5. Hospital staff, Clothing Room Volunteers or Unit Volunteers must accompany the resident in selecting clothing at the Clothing Room.

6. The resident is not to be left alone in the Clothing Room.

7. Residents should be actively involved in selecting clothing, if this is not feasible, nursing staff or volunteers may assist the resident in selecting clothing.

8. The Clothing Room Form must be completed by hospital staff or volunteers and submitted to the Clothing Room.

9. If a Clothing Room Volunteer is unavailable, hospital staff (Social Worker, Nursing staff, Activity Therapist or Neighborhood Volunteer may obtain the key from the Nursing Station. All Neighborhoods have access to the clothing room 24/7. An ID badge which gives access to the 4<sup>th</sup> floor entrance as well as a key to the clothing room was made available to all neighborhoods as well as the Social Work Department

~~and the Administrative Office.) or Unit Volunteer may obtain the key from the Social Work Department or Volunteer Services by signing the sign out sheet. Hospital staff and volunteers must return the keys to the Department key was obtained from, and sign them back in.~~

Hospital staff and volunteers must ensure that the Clothing Room is left in an orderly fashion.

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10. Clothing room forms will be compiled, and quarterly reports of clothing usage will be made to the volunteer coordinator.

11. Clothing Room Hours are Mondays and Fridays from 10AM to 2PM. The extension to reach the Clothing Room at Laguna Honda Hospital is x44036



**ATTACHMENT:**

None

**REFERENCE:**

None

Most Recent Review: 12/08/17

Revised: 12/08/17, [15/07/01](#)

## RESIDENT LIBRARY

### POLICY:

Laguna Honda Volunteer Services manages the operations of the resident library, including the acquisition and organization of donated and purchased reading materials, the provision of computers and internet access, and volunteer staffing of the library.

### PURPOSE:

To enhance the quality of life of LHH residents.

### PROCEDURE:

1. The Library is open Monday to Friday 8:30 a.m. to 8:00 p.m. During the week, the library is opened by the Activity Therapy Department Supervisors and closed by EVS Staff, after cleaning. On Weekends, Activity Therapy Staff open the Library at 9:30am and close it at 4:30pm.
2. The Volunteer Services Department acquires books for the library through a book share program with the San Francisco Public Library and the Friends of the San Francisco Public Library.
3. The Volunteers Services Department maintains subscriptions of periodicals financed by Friends of Laguna Honda a private non-profit volunteer auxiliary.
4. Computing:
  - a. Computers with internet access are available to the residents during regular library hours. The library computers are for use by residents only, or staff assisting residents who are present.
  - b. ~~The internet access is restricted from adult pornography in the library. Although internet access is not restricted,~~ Residents & visitors have the right not to be exposed to sexually explicit materials or behaviors, under the LHH Resident's Sexual Rights and Responsibilities Policy.
  - c. Computer, internet, access are maintained by Volunteer Services staff and volunteers. ~~IT at Laguna Honda does maintain problems with access to the internet.~~
5. The Resident Library has a large selection of enlarged print books, and has equipment designed to magnify text for the visually impaired.

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6. Volunteer librarians staff the library providing assistance to and supervision of responsibilities. Responsibilities of volunteer librarians include:
    - a. Assist residents with locating reading materials
    - b. Enforce library policies
    - c. Assist residents with use of the computers (internet, email, etc.)
    - d. Enforce the rule that the computers are for resident use only
    - e. Shelf books appropriately (by genre, then alphabetically, by author, then title)
    - f. Organize periodicals in a manner that enhances access and utilization by residents.
    - g. Organize/clean up tables and chairs to provide the greatest access possible for residents.
  
  7. The Resident Library may not be used for any staff-related functions.

**ATTACHMENT:**

None

**REFERENCE:**

None

Most Recent Review: ~~1544/0708/2320~~  
Revised: 14/08//20  
Original Adoption: 98/06/01

## HOLIDAY GIFT PROGRAMS

### POLICY:

Friends of Laguna Honda provides \$30,000.00 annually for resident gifts to be distributed during the holiday in December.

### PURPOSE:

To ensure that each resident receives gifts that is appropriate for each individual resident.

### PROCEDURE:

1. The Volunteer Services Department is responsible maintaining an accurate inventory of gifts.
2. The shipment of merchandise will begin arriving during the end of summer and beginning of Fall. The Volunteers Services Department (VSD) is responsible for recruiting volunteers to assist with inventory and packaging of the gifts.
3. A catalog of items is created by theVSD to determine what residents can select from (e.g.g. clothing, jewelryperfumes, stationary, etc.)
  - a. Activity Therapists are given a the catalog so that they can discuss with the resident what he/she would like to receive.
  - b. Each resident will be offered to choose gifts totaling up to \$30.00.
4. ~~4.~~—The Volunteer Services DepartmentVSD will begin to process the orders in the month h of November of November.
5. —Once the orders are filled, the Volunteer Services DepartmentVSD will contact the Activity Therapist to arrange a gift  
—delivery schedule and gifts are delivered as appropriate.
6. If items ordered are not available, the Volunteer Services DepartmentSD will inform the Activity Therapist of  
—substitutes. If these substitutions are not appropriate, Activity Therapists will contact  
—the Volunteer Coordinators who will offer other items available in the inventory.
7. The gifts are to be distributed to residents by nursing staff and/or Activity Therapists generally during the holiday parties. Activity Therapists are responsible for ensuring

that each resident receives their gifts.

8. After the holiday gifts are processed and distributed, the [Volunteer Services Department](#) is responsible for taking an accurate inventory for the next year.

**ATTACHMENT:**

None

**REFERENCE:**

None

Most recent review: 14/08/20

Revised: 15/03/20, ~~15/08/1920~~

Original adoption: 08/08/25

## **VOLUNTEER PLACEMENT PROGRAM**

### **POLICY:**

The Activity Therapy Department will designate Activity Therapy staff to be the Point of Contact to oversee all volunteer activities within the Department.

### **PURPOSE:**

1. To comply with Volunteer Placement procedures outlined by Laguna Honda Volunteer Services Department.
2. To ensure safe, high quality service delivery by volunteers.

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(Definitions: POC - Point Of Contact)

### **PROCEDURE:**

1. Activity Therapy Management will create the POC role into an assignment as part of his/her job duties.
2. POC will collaborate with Volunteer Coordinators to:
  - i. Process interested volunteers, ensure identification and health screens have been completed.
  - ii. General updates on current volunteer pool.
  - iii. Reports excessive absences, tardiness and other volunteer concerns.
  - iv. Updates on safety and other hospital policies.
3. POC will collaborate with Activity Therapy staff to:
  - i. Reviews staff interest in supervising volunteers.
  - ii. Updates interested staff on available volunteers.
  - iii. Coordinates with staff about workflow logistics.
  - iv. Collects the needs of residents, ranging from 1:1 friendly visits to interest in attending hospital wide programs.
  - v. Connects volunteer resources with staff interested in supervising volunteers.
  - vi. Supports supervising Activity Therapists in potential conflicts with volunteers.
4. POC will meet with Volunteers to:
  - i. Discuss and finalize placement & schedules. Placement may include transport services to hospital wide program, Hospital wide programs support and/or Activity Therapy supervised neighborhood support.
  - ii. Supports Supervising Activity Therapists in potential conflicts with volunteers.
  - iii. Reviews departmental safety practices & Activity Therapy volunteer operations.
5. POC will also collaborate with Nursing and other departments where volunteers are placed to ensure communication and safety practices have been discussed and followed through.

### **REFERENCES:**

Laguna Honda Hospital Volunteer Services Policies and Procedures File A 3.0 Volunteer Placement Policy

### **ATTACHMENT:**

None

Adopted: 8/13/2015

## NEIGHBORHOOD MONEY/SHOPPING TIME

**Policy:** Money is made available monthly to purchase items that would benefit the residents of each neighborhood. The money is the result of the on-going donations from Friends of Laguna Honda. The Activity Therapy Department is responsible for the appropriate utilization of this resource.

**Purpose:** To enable the purchase of items that will enhance the lives and living environments of the residents of Laguna Honda Hospital.

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### Procedure:

1. The amount of money available to each neighborhood on a monthly basis is established and modified at the discretion of Friends of Laguna Honda Hospital through the Director of Therapeutic Activities provide recommendation for neighborhood money funding.
2. At the beginning of each month, an Activity Therapy Supervisor receives a check from Accounting as reimbursement for the prior month's purchases and cashes the check at the cashier's office in order to distribute the funds to each neighborhood.
3. The Neighborhood Money is distributed to the Activity Therapists assigned to each neighborhood as close to the beginning of the month as possible using the Neighborhood Money Sign Out Form.
4. Items purchased are at the discretion of the Activity Therapists after consultation with the residents and staff of the neighborhoods. Examples of items purchased with Neighborhood Money are game prizes, decorations, games, arts and crafts supplies, etc.
5. Paid time to leave the facility and buy items to be used on resident neighborhoods is allocated to Activity Therapist with primary neighborhood assignments at a rate of four hours per neighborhood. Staff members may divide the shopping time amongst themselves as appropriate.
  - a. Activity Therapists are required to sign-up for shopping time at least 24 hours prior to taking shopping time with the appropriate Activity Supervisor.
  - b. The Activity Therapist must notify the appropriate Supervisor either verbally or in writing if they are scheduled to take shopping time during an evening or weekend.
  - c. The Activity Therapy Supervisor will contact the Activity Therapist if there is any conflict with the shopping time.
  - d. Shopping time can not be taking at a time that will conflict with routine responsibilities of the Activity Therapist including programs and regularly scheduled meetings and in-services.
  - e. Shopping time can only be utilized at the beginning or the end of a shift.
  - f. Shopping time can not be used in conjunction with benefited time off.
6. The Activity Therapist shall fully spend the total amount allotted each month. If the full amount of money allocated is not spent, neighborhood Activity staff will retain the money not spent and apply it to the next month. The neighborhood will then receive the amount

of money that equals the sum of the receipts submitted. Any neighborhood that exceeds the monthly amount will not be compensated for the overage.

7. The Activity Therapists are responsible to submit receipts for all purchases to Activity Therapy Supervisor responsible for neighborhood receipts generally by the last Wednesday of the month using the Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form.
8. All receipts must
  - a. be dated within the month that the funds were allocated.
  - b. have the date of purchase noted.
  - c. be submitted taped on the back of the Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form.
  - d. identify the business establishment at which the purchase is made.
  - e. be itemized.
  - f. be from a register. Hand-written receipts are to be avoided. If hand-written receipts become necessary, a representative of the business must sign a receipt, list items purchased and supply a business address and phone number.
  - g. no receipts from outings can be used.
  - h. meet these requirements. If they do not they will not be accepted for processing. If receipts are not accepted, the neighborhood will receive the amount of money the next month that equals the sum of accepted receipts.
9. Receipts are collected from each neighborhood and all are submitted to accounting together for reimbursement using the Laguna Honda Hospital City and County of San Francisco Gift Fund-Revolving Fund Reimbursement form by an Activity Therapy Supervisor.

**Attachments:**

None

**References:**

Laguna Honda Hospital City and County of San Francisco Gift Fund Revolving Fund Reimbursement form

Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form

Neighborhood Money Sign Out Form

Most recent review: 06/29/15  
Revised: 04/14/13, 03/10/15, 06/29/15



# Neighborhood Money \$200.00

Month/Year \_\_\_\_\_

Please print and sign next to neighborhood you are receiving.

<b>PM -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>S2 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>S3 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>S4 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>S5 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>S6 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>NM -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N1 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N2 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N3 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N4 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N5 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

<b>N6 -</b>	<u>Activity Therapist</u>		
	Print Name	Signature	Date

**LAGUNA HONDA HOSPITAL  
CITY AND COUNTY OF SAN FRANCISCO  
GIFT FUND – REVOLVING FUND REIMBURSEMENT**

**To:** Accounting Department

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_  
Print Name

**Telephone No.** \_\_\_\_\_

**Fund:** 5L TAF ETF      **Index Code:** HLH450221      **Grant/Detail:** \_\_\_\_\_

**Sub Object:**      04699 \$ \_\_\_\_\_      04961 \$ \_\_\_\_\_      04999 \$ \_\_\_\_\_

03571 \$ \_\_\_\_\_      03599 \$ \_\_\_\_\_      \_\_\_\_\_ \$ \_\_\_\_\_

**Total Requested Amount:** \$ \_\_\_\_\_      **Date(s) of expense:** \_\_\_\_\_

**Reason for Expenditure:**

Community Outing       Hospital-Wide Programs       Neighborhood Money       SATS

---

**Patient's Name (if applicable):**

1. \_\_\_\_\_      5. \_\_\_\_\_      9. \_\_\_\_\_  
2. \_\_\_\_\_      6. \_\_\_\_\_      10. \_\_\_\_\_  
3. \_\_\_\_\_      7. \_\_\_\_\_      11. \_\_\_\_\_  
4. \_\_\_\_\_      8. \_\_\_\_\_      12. \_\_\_\_\_

**Staff and/or Volunteer's Name (if applicable):**

1. \_\_\_\_\_      3. \_\_\_\_\_      5. \_\_\_\_\_  
2. \_\_\_\_\_      4. \_\_\_\_\_      6. \_\_\_\_\_

**Requested by:** \_\_\_\_\_      \_\_\_\_\_      **Date:** \_\_\_\_\_  
Employee: Print Name      Signature

**Pre-approved by:** \_\_\_\_\_      \_\_\_\_\_      **Date:** \_\_\_\_\_  
Division Head: Print Name      Signature

(or)  
**Pre-approved by:** \_\_\_\_\_      \_\_\_\_\_      **Date:** \_\_\_\_\_  
Mivic Hirose, CEO

**Approved by:** \_\_\_\_\_      \_\_\_\_\_      **Date:** \_\_\_\_\_  
ChiaYu Ma, CFO

**Note: Original receipts/invoices must be attached when submitting to Accounting.**

Revised: May 21, 2015

## **EMERGENCY RESPONSE PLAN**

### **POLICY:**

Activity Department will lead in the assessment and coordination of needs for particular areas of the hospital during a Department Emergency and Disaster Response.

### **PURPOSE:**

1. To streamline information to the Disaster Response Command Center
  2. To ensure the well being of residents for residents in those designated areas.
- 

### **PROCEDURE:**

1. Code Yellow is announced, Department Emergency/ Disaster Response Plan will be activated.
2. During normal business hours (8:30am-5pm), non-neighborhood Activity Therapy personnel will initiate the Department Operations Status Report, collect information in the 1<sup>st</sup> Floor Pavilion area between the rooms P1111 and P1162, Ground floor Rooms PG 222 and 223 (Wellness and Pool), and Farm.
3. The information of the 1<sup>st</sup> floor pavilion areas will be taken to Nursing Office (P1). The information pertaining to PG 222, 223 and Farm will be taken to Ground Floor Lobby.
4. Activity Therapy Staff should be prepared to manage residents in the common spaces if necessary.
5. Farm staff should be prepared to move animals, provide First Aid, and call a veterinarian if necessary.

### **REFERENCES:**

Emergency Response Plan

### **ATTACHMENTS:**

None

Most recent review: 4/20/2015  
Revised: 6/2014, 8/29/2014  
Adopted: 2/2014

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## TRACKING OF RESIDENT PARTICIPATION

### POLICY:

The Activity Therapy Department maintains records of resident participation in activities.

### PURPOSE:

To comply with California state regulations and to assist with resident care planning.

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### PROCEDURE:

1. Neighborhood based activities
  - a. Activity staff assigned to the neighborhoods utilize the "Activity Therapy Group Attendance Record" to document resident(s) daily participation in activities.
    - i. Activity staff maintain the form with the neighborhood's residents full name.
    - ii. Activity staff list the group activities along the top vertical section. The group activities coincide with the neighborhood calendar for each day. Slots are left blank to allow the recording of additional groups as needed.
    - iii. If a group provided differs from the neighborhood calendar, "Scheduled programs were changed due to:" shall be marked with reason for change noted.
    - iv. Resident participation is recorded at the intersecting square between the residents name and the activity: "A" is used for "Active", "P" "Passive", "D" "Declined", and "N" "Not Available" is the preferred notation.
    - v. The notes section is utilized for the recording of individualized activities including 1:1 interventions, non-neighborhood program attendance, and resident independent leisure activities. 1:1 interventions must be recorded here to be tracked.
  - b. One form is used for each day of the week.
  - c. Completed forms are maintained on the neighborhood binder for 3 months. Records older than 90 days are transferred and stored in the specific neighborhood attendance record binder in the activity therapy department.
  - d. Neighborhood participation records are maintained for one year, after which they are discarded using confidential shredder bins.

#### Hospital-wide activities

- a. Activity staff record and maintain hospital wide activity participation electronically.
- b. Records are saved in the departmental L drive.
- c. Records include:
  - a. Residents full name
  - b. Neighborhood in which they reside

- c. Date of the activity
  - d. Title of the activity
  - e. Mark residents participation
- d. Completed records are maintained for 1 year.

**REFERENCE:**

Code of Federal Regulations: 42CFR 483.00  
California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section  
Activity Therapy Group Attendance Record Guidelines

**ATTACHMENT:**

1: Neighborhood Activity Therapy Group Attendance Record Form

Most recent review: 6/18/2015  
Revised: 10/18/2010, 8/15/2012, 9/2013, 8/29/2014, 6/18/2015  
Adopted: 8/21/2008

## Activity Therapy Group Attendance Record Guidelines

Complete **date, day, & neighborhood** for each day of month. Include notation when no AT is present such as sick, vacation, or regular scheduled day off.

Write **group activities** [match neighborhood calendar] in vertical spaces above resident(s) names.

Complete group attendance [i.e., A, P, D, N] & write **AT initials** in box above.

If group provided differs from neighborhood calendar, check "**Scheduled programs were changed due to:**" & write reason.

**Notes Section:** This section is utilized for individualized 1:1 interventions &/or independent leisure activities such as MDS interview, room visit, offering / providing materials for personal use, Skype, independent stroll off-unit, church, visitors, personal device usage, etc. Circle leisure activities when observed &/or write in new entries as needed.

**"AT Signatures" & "Date Completed."** Sign & date after completing attendance &/or "notes" section.

Please keep extra blank attendance records in binder to be utilized by others if needed.

Current attendance records to be kept on neighborhood for 3 months. Neighborhood ATs to submit appropriate records to AT department office by 10<sup>th</sup> of each month. AT department office to retain neighborhood attendance records for 1 year.

Thank you!

## MEDICAL RECORD DEFICIENCY RESOLUTION

### POLICY:

Activity Therapy will minimize medical record deficiencies.

### PURPOSE:

1. To ensure Activity Therapy medical records are thorough and accurate.
2. To ensure that records needing retirement are kept to a minimum.
3. To ensure closed records are complete within 30 days post discharge.

### DEFINITIONS:

1. "HIS" Health Information Services Department
  2. "AT" Activity Therapist
- 

### PROCEDURE:

1. Reporting Information-HIS will provide The Activity Therapy Department with information regarding deficient or incomplete records.
  - a. Each employee is provided with a list of incomplete and deficient records every other week.
  - b. A list of the total deficiencies for the department is provided to the Director monthly.
2. Activity Therapist Responsibility- the AT or provider of services is responsible for ensuring documentation is complete and accurate. Incomplete and deficient records must be resolved.
  - a. AT will go o the incomplete desk in HIS
  - b. AT will request incomplete and deficient records are pulled for review.
  - c. AT will review each deficiency to determine how to resolve the deficient record.
    - i. If the record is the responsibility of the reviewer, then determine if the record can be corrected or recovered. Please follow the guidelines below.
      - AT staff should correct all signatures and initial errors.
      - AT staff should complete participation records that are less than one year old. The missing record may be located in the follow places;
        - ⇒ A volume from a different episode (admission).
        - ⇒ The attendance book on the unit.
        - ⇒ ETC.
      - If the record can not be located, then create a new record by;
        - ⇒ Completing the top section (month and unit)
        - ⇒ In the addressograph section, write the residents name and medical record number.
        - ⇒ If appropriate, fill in admission or discharge in the activity column, and check the date that corresponds with the activity.

- ⇒ If you are not able to identify specific information for the record, then line through the front of the record, add AT initials and date.
  - AT should complete missing assessments that are less than one year old.
    - ⇒ Any assessment since June 2008 should be available in the electronic files. If it is available in the electronic files, print, sign and turn in to HIS.
    - ⇒ If it is not available, AT will need to complete a new one.
  - ii. Other situations must be noted on the deficiency list and returned to the Activity Therapy Supervisor for follow up. Below are situations that should be noted on the list.
    - If the record is not the responsibility of the reviewer, it must be reassigned. Note on the list that the record must be reassigned, and if possible, to whom it should be reassigned.
    - If the document is missing and is more than one year old and can not be located, it must be retired by a supervisor. Note specific missing document information, i.e. month, year, etc and that it needs to be retired on the deficiency list.
    - Note all completed/resolved deficiencies on the list.
    - Return the deficiency list to the Activity Therapy Supervisor.
3. Activity Therapy Supervisor Responsibility
- a. Review each employees incomplete and deficiency list for policy compliance monthly.
  - b. Review the list with the employee, and emphasize the “easy fixes” and how to resolve the deficiencies, see above, and distribute.
  - c. Resolve deficiencies for AT staff who are out for extended periods of time, (i.e. 30 days or more).
  - d. Re-collect the lists with resolution data from the AT, monthly.
  - e. Reassign and retire records as needed using the Incomplete Records form letter. (See Appendix A).
  - f. Maintain a record of the follow up in the employees departmental performance file for performance appraisals.
  - g. Provide a copy to the Activity Therapy Supervisor responsible for HIS issues.
4. Departmental Responsibility
- a. Review statistics during supervisors meeting monthly.
  - b. Develop strategies for increase compliance and incomplete record reduction.

**REFERENCE:**

Health Information Services Policies &amp; Procedures

**ATTACHMENT:**

1: Retirement Letter Form

Deleted: 7/6/2015  
Revised: 9/2013, 8/29/2014  
Adopted: 9/2013



## COMMUNITY OUTING PROGRAM

### POLICY:

The Activity Therapy Department plans and implements community outings for the residents of Laguna Honda Hospital.

### PURPOSE:

1. To enhance the quality of life for the residents of Laguna Honda Hospital.
2. To reduce boredom and isolation resulting from long term hospitalization.
3. To promote a sense of normalcy through contacts with the surrounding community.
4. To promote the reintegration of residents back into the community.

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### PROCEDURE:

1. The Community Outing Coordinator develops a schedule of outings each month at least one week prior to the first of the month.
  - a. Community Outings are scheduled by the following priority:
    - i. Unit specific outings - Activity Therapists are responsible to plan community outings that meet the needs and interests of the residents of his or her assigned neighborhood(s). The Activity Therapy Department establishes a requirement of bus trips that are available to individual neighborhoods. The implementation of outings is job performance expectation and a requirement. These outings generally occur at a rate of two per month per neighborhood, one of which may be an outing to a restaurant.
    - ii. Hospital-wide specialty trips - are unique opportunities for community outings that result from the purchase or donation of tickets & the availability of a program or event that are appropriate to a particular group of residents.
  - b. The schedule is developed with the schedules of the drivers. Drivers are required to submit requests for time-off to the Outing Coordinator & Assigned Nursing Director. Request for time off are approved based on seniority. Approval comes from both the Nursing Department and Activity Therapy Department. Additional request for time off must be made by the fifteenth of the prior month.
  - c. Activity Therapists must sign up for outings in advance on the community outing schedule binder located in the Activity Therapy office. The Community Outing Coordinator will communicate any conflicts with proposed dates for Activity Therapy outings with the assigned Activity Therapist and Supervisor and an alternate date is arranged.
2. The Community Outing Coordinator distributes the bus trip schedule to the following:
  - a. Drivers
  - b. Resident Neighborhoods
  - c. Nursing office
  - d. Volunteer Services Department
  - e. Activity Therapy Department
3. The Community Outing Coordinator is responsible to maintain, distribute, and document appropriate utilization of funds.

- a. Cash is requisitioned from the Financial Services Department on as needed basis. This generally occurs once per week. Receipts from previous requests are submitted at the time of the new request and unspent funds returned.
  - b. The Activity Therapist is responsible for handling cash during an outing. The Activity Therapist is responsible for returning receipts and unused cash along with a list of residents, staff and volunteers who participated in the outing to the assigned Activity Therapy Supervisor. Receipts and unused money is submitted to the back-up supervisor in the absence on the primary supervisor. Hand-written receipts are to be avoided. Receipts must bare the name of the business establishment at which the purchases were made. Separate restaurant receipts for residents and staff are required.
  - c. The Activity Therapy Supervisor ensures accuracy of the money and receipts and submits all materials to the Community Outing Coordinator using the "Gift Fund Reimbursement, Bus Trip Only" form.
4. Staffing for community outings may include the following:
- a. Driver, schedule coordinated by the Community Outing Coordinator.
    - i. Drivers are Certified Nursing Assistants and are required to maintain current CPR certification as a condition of employment.
    - ii. Drivers must maintain a current Class B California Drivers License.
  - b. PCA or CNA, schedule coordinated by the Neighborhood Nurse Manager.
    - i. Neighborhood based community outings require the inclusion of at least one Nursing Assistant who is regularly assigned to the neighborhood.
    - ii. For hospital-wide outings, a PCA or CNA is assigned by Nursing Office to support the outing.
  - c. Volunteers, schedule coordinated by the Volunteer Services Department.
  - d. Family members of residents may participate in the community outing program. Participation of family members in a community outing is coordinated through the assigned Activity Therapist. Family members are responsible for providing their own meals during the outings. Family members are responsible for any admission fees and other costs related to outing.
5. The Activity Therapy staff are responsible for the following:
- a. Identifying residents to attend and communicating with the appropriate unit staff.
  - b. Ensuring a physician's order has been written for resident participation in community outings.
  - c. Determining the time of the outing.
  - d. Requisition of bag lunches with resident's full name to the Nutritional Services Department and dietary restrictions on Community Outing Planning Form. The Planning Form must be completed and signed by the appropriate Nurse Manager and Activity Therapy Supervisor and submitted to the appropriate Activity Therapy Supervisor at least two weeks in advance of the outing date.
  - e. Coordinating details such as admission fees, accessibility, and special arrangements with personnel at the outing destination.

- f. Making reservations and coordinating details such as accessibility, and special arrangements with personnel at a restaurant and/or other destinations.
  - g. Determining staff and volunteer support needed for the outing. Volunteers are not utilized for restaurant outings. The form is also submitted the Volunteer Services Department if appropriate at least two weeks in advance of the outing date.
  - h. Leading the overall outing effort, coordinating with supportive staff on their roles to ensure resident enjoyment and safety.
6. Use of Hospital Vans for Community Outings.
- a. The hospital has vans that are equipped to accommodate residents using wheelchairs. These vans may be used by Activity Therapy and other hospital staff to take residents on community outings. The focus of these outings is to enable residents to attend or participate in an event of specific interest. These outings may also be used as treatment to help reintegrate residents into the community.
  - b. Scheduling of the van requires primary notice to the Community Outing Coordinator of specific date and time and is scheduled based on availability.
  - c. Staff driving on the outing must be oriented to the proper use of the van, the lift and tie-down system.
  - d. Staff facilitating community outings using the hospital vans assumes responsibility for managing monies and returning the used money and receipt to the Community Outing Coordinator.
  - e. Staff using the van for any reason must have their drivers' information on file with the Human Resource Services Department.
  - f. Staff will pick up the van keys, emergency procedure, and parking placard from the Community Outing Coordinator prior to the outing and return those items upon return.

**REFERENCE:**

Nutritional Services Policy and Procedure 1.132 Catering Requests.  
Activity Therapy Community Outing Protocols.

**ATTACHMENT:**

1: Therapeutic Outing Planning Guide and Bag Lunch Request

Deleted: 5/12/2015 (replaced by HWPP 28-01)  
Revised: 8/3/2009, 10/15/2010, 7/1/2012, 12/27/2012, 4/11/2013, 9/2013,  
8/29/2014, Deleted 5/12/2015  
Adopted: 6/1/1998

**Laguna Honda Hospital Activity Therapy Department  
Therapeutic Outing Planning Guide and Bag Lunch Request**

Staff Name \_\_\_\_\_ Phone: \_\_\_\_\_ Neighborhood \_\_\_\_\_ Date \_\_\_\_\_

Destination \_\_\_\_\_ Day/Date \_\_\_\_\_

Departure Time: \_\_\_\_\_ Return Time: \_\_\_\_\_ Loading Time: \_\_\_\_\_ Loading location: \_\_\_\_\_

	Resident Name	* N'hood	Bed #	Diet	Precautions	Code Status
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
	Back Up Resident Name	N'hood	Bed #	Diet	Precautions	Code Status
1						
2						
3						

Number of Resident Lunches \_\_\_\_\_ Number of Staff/Volunteer Lunches \_\_\_\_\_ Total \_\_\_\_\_ Pick Up Time \_\_\_\_\_

**ACTIVITY THERAPY DEPARTMENT**  
**Therapeutic Outing Planning Guide**

**Funding Request**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_ Total: \_\_\_\_\_

Amount Received: \_\_\_\_\_ Signature: \_\_\_\_\_

Amount Received: \_\_\_\_\_ Signature: \_\_\_\_\_

**Volunteer Request#** \_\_\_\_\_

**Describe Volunteer Tasks**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Special Considerations** \_\_\_\_\_

**Approval**

**Nurse Manager** \_\_\_\_\_ **Activity Therapy Supervisor** \_\_\_\_\_

\* Indicates that physician's order has been obtained on reverse side of this form.