List of Hospital-wide/Department Policies & Procedures Submitted to JCC for Approval on January 12, 2016

1. ***a. New Hospital-wide Policies and Procedures***		
Policy Number	**Title**	**Comments/Reason(s) for Policy & Procedure Development**
LHHPP 20-09	**Short Stay**	Created to identify and prioritize short-stay residents who have the potential to be discharged in less than 100 days.
LHHPP 24-12	**Laguna Premier Club: Neurobehavioral Day Program**	Created to provide individualized smaller group, therapeutic, nurse-driven activities that are resident-centered.
b. New Department Policies and Procedures		
	Department: Nursing	
Policy Number	**Title**	**Comments/Reason(s) for Revision**
NPP I 12.0	**Chest Tube Care and Maintenance**	To outline care procedures for a resident that requires a chest tube.
	Department: Psychiatry	
Policy Number	**Title**	**Comments/Reason(s) for Revision**
MSPP D08-02	**LHH Department of Psychiatry Overview**	Describes the general mission, organization and scope of Psychiatry services.
2. ***a. Revised Hospital-wide Policies and Procedures***		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
LHHPP 01-00	**Value, Mission and Vision Statements**	Updates the new values, mission and vision of LHH.
LHHPP 01-01	**Approval and Format Of Hospital-Wide and Departmental Policies and Procedures**	Adds informational updates contained in appendices (such as names of personnel, contact numbers, name of vendors, etc.) will not need to be approved by the JCC.
LHHPP 01-04	**Committees – Mandated**	Clarification of committees and submission of minutes to the Medical Executive Committee.
LHHPP 01-10	**Departmental Responsibility and Accountability**	Clarification of department managers to update the departmental/service policies and procedures on the LHH intranet and the inclusion of the list of LHH departments and services.
LHHPP 22-01	**Abuse Prevention, Identification, Investigation and Response**	Revised Resident Assessment and Care Planning following allegations of resident abuse.
LHHPP 22-07	**Physical Restraints**	Adds and clarifies what elements the RCT members must evaluate when determining if confinement is necessary.
LHHPP 22-10	**Management of Resident Aggression**	Incorporation of behavioral health assessments procedure and staff witness or victims of aggression

		procedure. Revision of management of aggressive behavioral crisis procedure.
LHHPP 24-06	**Resident Complaints**	Update of resident complaint/grievance process and change of title to include Grievances.
LHHPP 26-02	**Management of Dysphangia and Aspiration**	Update of procedures. Clarification of follow-up procedures – documentation of reasons for discontinuation of Specialized Feeding Plan form in medical record.
LHHPP 31-01	**Wireless Refrigerator and Freezer Temperature Monitoring System**	Change of title to reflect the policy and procedures. (Retitled Wireless Refrigeration and Warming Temperature Monitoring System.)
LHHPP 31-02	**Hospital Equipment and Supplies Budget and Procurement**	Revision of title and inclusion of Materials Management and Central Supply department role in inventory of control policies and procedures.
LHHPP 50-02	**Resident Trust Fund**	Revised to include role of A&E financial counselor.
LHHPP 50-08	**Laguna Honda Resident Notification of Excess Personal Assets**	Inclusion of regulations feigned by the Medi-Cal program.
LHHPP 60-13	**Patient Safety Committees and Plans**	Update of committee names.
LHHPP 70-04	**Code Silver**	Clarifies when to call the Sheriff and necessary communication measures that should be taken during code silver.
LHHPP 71-12	**Fire Drill**	Update of Laguna Honda Hospital Fire Drill Participation form in Appendix B.
LHHPP 72-01 C2	**Standard Precautions**	Revised to include safe injection practices and respiratory hygiene/ cough etiquette.
LHHPP 72-01 C5	**Transmission-Based Precautions and Resident Room Placement (New Name)**	Revised, renamed and consolidated to include: C5 High Level Respirator Isolation C7 Low Level Respiratory Precautions C10 Resident Room Placement Guidelines C12 Special Contact Isolation
LHHPP 72-01 C8	**Medication Handling and Dispensing Guidelines**	Adds procedures and references.
LHHPP 72-01 C16	**Scabies Management**	Adds prevention and control procedures with appendices.
LHHPP 72-01 D3	**Antibiotic Use Guidelines**	Inclusion of reference to Lexicomp e-Formulary for antibiotic formulary and Infectious Diseases Management Program (IDMP) website.
LHHPP 72-01 D4	**Evaluation of Communicable Illness in Personnel**	Streamlined through the addition of infection control / occupational health tables for disease specific illness and guidance for staff, incorporating other infection control P&Ps described in D5-D28.
LHHPP 72-01 E1	**Activity Therapy**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members:

		• LHHPP 76-03 Animal Control • LHHPP 26-05 Neighborhood Specialty Meal Program • LHHPP 28-01 Community Outing Program • 28-02 Farm and Therapeutic Gardens • 28-03 Aquatic Services • 28-04 Pool Servicing and Aquatic Area General Maintenance • Activity Therapy Policy P5.0 Animal Assisted Therapy
LHHPP 72-01 E3	**Barber and Beauticians**	Minor revisions: changed: "patient" to "resident" for consistency.
LHHPP 72-01 E4	**Central Supply/Materials Management**	Reformatted and added "/ Materials Management" to title.
LHHPP 72-01 E5	**Clinical Laboratories**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • A1 - Clinical Laboratory • A2 - Phlebotomy Procedure • A3 - Identification of Patient and Collection of Blood Specimen • A4 – Blood Culture Procedure
LHHPP 72-01 E6	**Dental Services**	Minor revision: changed title to "Dental Services".
LHHPP 72-01 E7	**E.K.G.**	Minor revision: changed disinfection with Alva Quat to alcohol wipes and added disposable electrodes.
LHHPP 72-01 E8	**Food Service**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • Nutrition Services and Hospital-wide Policies • LHHPP 26-04 Resident Dining services • LHHPP S6-05 Neighborhood Specialty Meal Program • LHHPP 26-06 Meal Tray Service Galley Sanitation • And other Nutrition Services Department Policies and Procedures related to food procurement, food storage, safe food handling and preparation, meal service and food distribution, machine washing and sanitizing equipment, manual washing and sanitizing equipment, and cleaning of fixed food service equipment.
LHHPP 72-01 E9	**General Services**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: Environmental Services Policies and Procedures • IV Job Descriptions • XII Critical Areas Cleaning Procedure

		• XV. Pest Control and Animal Abatement • XVI Ice Machine and Refrigerator Cleaning • XVII Transport, Delivery Time for Biohazard, Trash and Linen • XVIII Microfiber Damp Mopping Cleaning • XX Cubicle Curtains and Drape Cleaning
LHHPP 72-01 E10	**Institutional Police**	Changed title to San Francisco Sheriff's Department Communicable Disease Management Policy.
LHHPP 72-01 E11	**Nursing**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: Nursing Policy and Procedures • Section D – hygiene and Comfort • Section J – Medication and Intravenous Therapy
LHHPP 72-01 E13	**Pharmacy**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: Pharmacy Policies and Procedures • Quality Improvement 03.03.00 Infection Control and Sterile Product Handling • 07.01.00 Sterile Product Preparation, Handling and Disposal
LHHPP 72-01 E14	**Physical Therapy**	Revised, renamed and consolidated to include: E14 Physical Therapy E12 Occupational therapy E19 Speech and Hearing
LHHPP 72-01 E15	**Facility Services**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • Facility Services Policies and Procedures, DP-31 Body Substance Isolation Procedure.
LHHPP 72-01 E16	**Radiology**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: Radiology Policies and Procedures • D2 Departmental Cleanliness Radiology Policies and Procedures, F2 Infection Control.
LHHPP 72-01 E17	**Respiratory Therapy**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • Respiratory Therapy Policies and Procedures, A4 Body Substance Isolation.
LHHPP 72-01 E20	**Outpatient Clinic**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • Outpatient Clinic Policies and Procedures, Section C.

		• Equipment Cleaning (also Environmental Services Policies and Procedures, XII Critical Areas Cleaning Procedure).
LHHPP 72-01 E21	**Volunteers**	Revised to list the following policies that are determined to be relevant Infection Control practices related to job functions of staff members: • Volunteer Services Policies and Procedures A4.0 Infection Control.
LHHPP 72-01 F5	**Standard for Refrigerators**	Title change and identifies applicable policies and procedures for monitoring the function and cleanliness of refrigerators.
LHHPP 72-01 F9	**Chemical Sterilization Standards**	Simplifies purpose statement and adds references.
LHHPP 72-01 G1	**Blood Spill Clean Up**	Update of references. Clarification that clinicians may clean up spills if a few drops and location of blood spill kits.
LHHPP 72-01 G5	**Cleaning and Disinfecting Non-critical Resident Care Equipment**	Inclusion of non-critical care equipment list. Update of non-critical equipment definition.
LHHPP 76-03	**Animal Control**	Clarification of companions for residents.
LHHPP 90-01	**Environmental Services**	Inclusion of procedure for parcels and packages for residents.
b. Revised Department Policies and Procedures		
Department: Nursing Services		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
NPP D1 2.1	**Nurse and Resident Call System**	Revision made as prompted by POC 2015: Policy: #7 All beside call light must be checked DAILY and shower & bathroom call lights are checked WEEKLY. Procedure B-3: Document in the DNCR (Intervention page): specified times when to document Added Attachment 4: DNCR Intervention Page for Checking Call Lights
NPP E 1.0	**Oral Management for Nutritional Needs**	Revisions as follow: Policy: #1 (add) “and aspiration precautions”. #2 Minor verbiage change. #3 Move to procedure. Re-phrase policy statement to: Nursing will inform RD and MD of unintended weight loss or gain. #4 Verbiage change. Family & volunteers will be educated regarding compliant food & beverages. #5 Simplify statement: Aspiration precautions will be documented in the RCP. Procedure:

		#1 (add) "and throughout the resident's stay"……."changes in the resident's ability to eat/swallow". #2 rephrase statement #3 moved from policy statement #6 (add) family, volunteers, and visitor to speak with nurse prior to offering resident any food #8 Verbiage change in the Line of Sight procedure (section a to f) #9 Designated Line of Sight staff will not be assigned other responsibilities during meal time #11 Food storage section from a to d #12 Documentation Add: supplement amount eaten documented on TAR Add: section d & e
NPP K 1.0	**Assessment, Prevention, & Management of Pressure Ulcer**	Change in Title. Major change in the entire policy & procedure. New appendices 1-4. Change in practices: 1. Use of 2 RNs to assessment wound. 2. Use of body diagram during transfer to acute, readmission, and relocation between SNF units. 3. When a resident is transferred to PMA, the sending SNF nurse and the receiving PMA RN will together assess the skin.
NPP M 5.0	**Protocol for Using Psychotropic Medications For Emergency Behavioral Situation**	Change in title from Using Psychotropic Medications on Unanticipated and/or Emergency Basis Deleted word "policy" as this is a protocol. Protocol #2 added as stated on Hospital-wide 25-10. Minor verbiage changes in #3 and added #4 "nurses will discuss with the physician any recommendation for any further revaluation by the psychiatric team".
Department: Pharmacy Services		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
Pharm 03.01.00	**Quality Assessment and Improvement**	Section on IV preparation and sterility testing, pharmacy compounding, and medication recalls have slight revisions to assure compliance with State Board of Pharmacy requirements.
Pharm 07.01.00	**Sterile Compounding**	Detail was added to the policy outlining cleaning products, cleaning procedures, conditions for every six month certification and testing, addition of specific quality checks to the compounding sheets, outline of staff education and testing for sterile compounding, increase the rigor of the quality assurance program for the sterile compounding program and removes the section on Preparation, Handling and Disposal of Hazardous Drugs into a separate policy.

Pharm 07.02.00	**Preparation, Handling and Disposal of Hazardous Drugs**	This policy used to be part of the sterile compounding policy. Due to the length, focus and scope of the sterile compounding policy it was determined that it would be preferable to have two separate policies. The content is unchanged in this section as we are awaiting the final rule of USP 800 which will delineate program needs for the hazardous drugs.
3. *a. Hospital-wide Policies and Procedures for Deletion*		
Policy Number	**Title**	**Comments/Reason(s) for Deletion**
LHHPP 72-01 C7	**Low Level Respiratory Precautions**	Consolidated in the new C5.
LHHPP 72-01 C10	**Resident Room Placement Guidelines**	Consolidated in the new C5.
LHHPP 72-01 C12	**Special Contact Isolation**	Consolidated in the new C5.
LHHPP 72-01 C20	**Animal Control**	Reflected in LHHPP 76-03 Animal Control.
LHHPP 72-01 D5	**Bloodborne Pathogens and Personnel: HIV, HBV, HCV**	Reflected in LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan.
LHHPP 72-01 D6	**Campylobacter Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D7	**Cytomegalovirus (CMV) Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D8	**Cold Symptoms (May 22, 2012)**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D9	**Conjunctivitis in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D10	**Coughing Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D11	**Dermatitis on Hands of Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D12	**Diarrhea, Vomiting, or Acute GI Illness in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D13	**Diphtheria Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D14	**Entervirus/Coxsackievirus Infection/Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.

LHHPP 72-01 D15	**Fever in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D16	**Giardia Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D17	**Hepatitis A Infection / Exposure in personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D18	**Herpes Simplex Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D19	**Influenza Immunization / Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D20	**Lice (pediculosis) Infestation / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D21	**Measles and Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D22	**Meningococcal Disease Exposure / Management in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D23	**Mumps Immunization / Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D24	**Rubella Immunization / Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D25	**Salmonella Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D26	**Scabies Infestation / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D27	**Shigella Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D28	**Staphylococcus Aureus Skin Infection in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 D29	**Tuberculosis Screening/ Infection / Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.

LHHPP 72-01 D30	**Varicella Immunization/Infection/Exposure in Personnel**	Reflected in revision of D4-Evaluation of Communicable Diseases in Personnel and new tables with each illness from SFGH infection control/ occupation health.
LHHPP 72-01 E12	**Occupational Therapy**	
LHHPP 72-01 E18	**Social Services**	Reflected in in hospital-wide policies for all staff: 72-01 Infection Control Manual C2 Standard Precautions; and 72-01 Infection Control Manual C4 Hand Hygiene.
LHHPP 72-01 E19	**Speech and Hearing**	Reflected in E14 Rehabilitation (combines E12, E14, E19).
LHHPP 72-01 F7	**Transport of Contaminated Instruments**	Obsolete per CSR.
LHHPP 72-01 G4	**Cleaning of Instruments**	Reflected in CSR Policies and Procedure: B7 Cleaning of Medical Instruments Prior to Disinfection or Sterilization.
LHHPP 72-01 G6	**Flash Sterilization**	Reflected in CSR Policies and Procedure: B9 Chemical Sterilization and B10 Steam Sterilization.
LHHPP 72-01 G7	**High Level Chemical Disinfection**	Reflected in CSR Policies and Procedure: B8 High-Level Chemical disinfection.
LHHPP 72-01 G9	**Steam Sterilization**	Reflected in CSR Policies and Procedure: B8 High-Level Chemical disinfection and B10 Steam Sterilization.
b. Department Policies and Procedures for Deletion		
	Department: None.	
Policy Number	**Title**	**Comments/Reason(s) for Revision**
None.		

SHORT STAY

POLICY:

Residents whose skilled nursing needs can be addressed in less than 100 days from admission are designated with the “Short Stay” hospital service code. The Short Stay code triggers a set of discharge planning activities aimed at facilitating discharge and mitigating delays that would keep the resident at Laguna Honda longer than 100 days.

PURPOSE:

Identify and prioritize short-stay residents who have the potential to be discharged and to improve the discharge planning process.

BACKGROUND:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) established the Short Stay hospital service code (LSS) effective January 1, 2014. This code designates residents expected to discharge from general SNF care to the community within 100 days of admission. Historically Laguna Honda has had other short stay codes such as LSA (Positive Care), LRH (Rehab), LRE (Respite), and LHP (Palliative Care) where residents’ stay is expected to be 100 days or less.

PROCEDURE:

1. ADMISSION

    a. The Admission and Screening Committee considers resident’s condition for admission using the Short Stay codes (LSS, LSA, LRH, LRE, LHP), based on the medical assessment of the appropriate course of treatment for the resident and the viability of the resident improving sufficiently for discharge within 100 days.

        i. The code is used primarily for residents who would otherwise be coded as General SNF (LHG).

    b. When the resident has been admitted, the Admission and Eligibility Unit inputs the hospital service code for the resident into the Invision system.

    c. For readmissions, the Patient Flow Coordinator will communicate the service code to Admissions and Eligibility, the receiving unit and the Utilization Management nurses.

2. Discharge Planning

a. Day of Admission - 14th day post admission. Discharge planning for Short Stay residents begins immediately on admission.

   i. Social Services – All residents must have an initial assessment within five days of admission and a discharge assessment within 14 days of admission. Social Services will conduct an initial assessment for Short Stay residents within two days of admission and a discharge assessment for Short Stay residents within seven days of admission.

   ii. Nursing – The admitting nurse will initiate discussion of discharge destination with resident or responsible.

   iii. Resident Care Team – An initial Care Team Conference will be held within 14 days of admission to discuss resident's goals of care and discharge plan.

b. Short Stay Weekly Discharge Discussion – Neighborhood Discharge Huddle:

   i. Resident Care Team – Resident Care Teams discuss all "Discharge Ready" (per the Discharge Status Report) residents at a weekly discharge huddle.

   ii. Nurse Manager or designee – will verify that the Hospital Code is correct and reflective of Short Stay.

   iii. Utilization Management nurses will affix a sticker in front to denote a short stay resident. Nursing will establish a practice of weekly summaries for short stay residents.

c. Bi Monthly Hospital-wide Short Stay Huddle:

   i. This huddle is facilitated by Director of Social Services and Utilization Management Nurse, attended by Neighborhood's Nurse Manager and Social Worker with residents who have Short Stay.

   ii. The intent of this discussion is to track that residents' Short Stay designation are within the track of discharge plan. Any Short Stay resident not meeting the planned discharge timeline will be referred to Discharge PIT to look at data and trends to improve processes and the UM Committee.

3. Change of Short Stay Codes

   a. A significant change in the resident's health condition will be the only reason for changing a resident's code from Short Stay to another hospital service code.

i. In cases where the resident's condition has changed such that a discharge within 100 days of admission is no longer viable, the resident care team notifies the Director of Social Services, either at a weekly Discharge Huddle or by direct contact.

ii. The Director of Social Services evaluates each code change request and meets with the resident care team to discuss the resident's former discharge plans and how the change in condition impacts those plans.

iii. If the Director of Social Services, with input from the Patient Flow Coordinator, approves the code change, s/he informs the Admissions and Eligibility Unit, which will update the coding from LSS to the appropriate code (e.g. LHG for general SNF).

b. The resident's length of stay begins anew with each readmission. Residents readmitted as Short Stay will have 100 days to discharge from the date of readmission.

c. Extenuating circumstances within the discharge planning process unrelated to the resident condition (e.g. housing delays, benefits delays) will not be criteria for changing a Short Stay code.

i. These factors will be recorded and monitored via the monthly Discharge Status Report.

d. Residents not discharged within 100 days but that have not had a significant change in health condition warranting a change in hospital service code will remain on the Short Stay code until discharge.

i. Metrics described below track the effectiveness of discharge planning efforts for residents on the Short Stay code.

4. Reports and Metrics
5.

a. Invision reports include a Short Stay list showing Medical Record Number, Resident Account Number, Resident Name, Neighborhood, Bed Number, Date of Admission on Short Stay Codes, Last Date on Short Stay Codes, and Number of Accrued Days from Admission.

b. The Patient Flow Coordinator will perform quarterly analysis of Short Stay residents for identification of learning and improved opportunities. For trend analysis, the following metrics will be reviewed quarterly:

i. Number and percent of residents designated as Short Stay.

ii. Number and percent of Short Stay residents discharged within the 100-day timeframe.

iii. Average length of stay for Short Stay residents.

iv. Summary characteristics of Short Stay residents (e.g. diagnosis, age, unit, discharge disposition) for trend analysis.

v. Number and percent of General SNF residents NOT designated Short Stay that discharged within 100 days.

c. Quarterly analysis will support performance improvement projects targeted toward specific sub-populations. Outcomes will be reported to both the Community Re-integration Performance Improvement Team and the Utilization Management Committee and ultimately through the PIPS committee.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: 16/01/12 (Year, Month, Day)

LAGUNA PREMIER CLUB: A NEUROBEHAVIORAL DAY PROGRAM

POLICY:

Residents with individual needs requiring additional support may be referred by the Resident Care Team (RCT) to the Laguna Premier Club (LPC), A Neurobehavioral Day Program.

PURPOSE:

To provide smaller group, therapeutic, nurse-driven activities that are resident-centered and flexible in order to meet the individual's unique needs.

BACKGROUND:

Long term care residents with cognitive and behavioral challenges have benefitted from a neurobehavioral day program consisting of smaller groups focused upon residents' individualized programming needs.

The neighborhood group activities serve the needs of most residents.

PROCEDURE:

1. Laguna Premier Club Referral Process

a. Resident must

  i. Be interested in attending small group based programs.

  ii. Be recommended to the LPC by the resident's RCT (Resident Care Team).

  iii. Must meet the program referral criteria below.

b. Criteria for Referral: (the first 5 criteria below are required)

  i. Evidence of neurobehavioral effects based upon neurological dysfunction..

  ii. Presence of behaviors that present challenges to the resident's neighborhood but are otherwise medically stable. These behaviors may include behavioral disturbances which are directly associated with the resident's brain injury or disease process, as well as other behavioral disturbances.

  iii. Sufficient auditory comprehension and attention to follow minimally complex conversations in a small group setting.

  iv. Socially acceptable toileting is maintained.

v. Ability to refrain from tobacco use during program hours.

vi. Need for close supervision (coach) due to complex neurobehavioral symptoms and behaviors (see Appendix A).

c. The RCT will determine if resident would benefit from individualized intervention in small groups to address specific targeted behaviors. Resident will then be referred to the LPC for evaluation.

d. Referrals may be made by Primary Care Provider, and/or any other member of the Resident Care Team (with RCT approval).

e. Pre Screening and Intake on the unit is completed by the LPC LVN and/or Behavior Specialist in conjunction with RCT.

f. The LPC LVN shall develop a customized schedule with input from neighborhood staff which shall include:

i. Target behavior(s)

ii. Pertinent diagnoses

iii. Current preferred neighborhood activity (to avoid schedule conflict)

iv. Possible activity/time preference for LPC

v. Potential for resident to resident aggression/triggers

g. Initial acceptance into the LPC will be on a trial basis to assess effectiveness of program for each individual resident. The RCT and LPC will review the trial results within 4 weeks.

2. Active Program Participation

a. Participants are provided a schedule at the time of their acceptance. The LPC team shall work to develop a rapport with the resident that is therapeutic and engaging in order to encourage their ongoing participation.

b. Under the supervision of the LPC Charge Nurse, the LPC LVN attends the Resident Care Conference (RCC) and shall serve as the primary neighborhood liaison to:

i. Coordinate resident schedules with neighborhoods (i.e. pick-up and returns to neighborhood),

ii. Discuss resident progress and share effective interventions while attending the program and on the neighborhood,

iii. Discuss any unforeseen issues that might have occurred during program time.

c. Residents are encouraged by LPC staff to remain as active participants. LPC staff will explore the reasons for refusal or absences and address as indicated. If residents continue to refuse to attend, they risked being discontinued from the program. RCT will be notified of the resident's discontinuation from the program by the LVN liaison.

3. Therapeutic Interventions

a. LPC staff are responsible for conducting smaller group, resident-centered activities that are therapeutic in structure.(See Appendix A)

b. Evaluation of the resident's response to the LPC will be reported regularly to the RCT by the LVN liaison.

ATTACHMENT:

Appendix A: LPC Therapeutic Structure

Original adoption: 16/01/12 (Year, Month, Day)

Appendix A:
Guideline
LAGUNA PREMIER CLUB Therapeutic Structure

1) The Laguna Premier Club (LPC) CNA/PCA staff are responsible for conducting small group activities that are therapeutic in structure.

    a) Three main categories of LPC groups include:

        i) Social Skills

        ii) Wellness

        iii) Thinking

2) Group Set up:

    a) The facilitator of the group shall arrange the participants in a semi-circle seated around a dry erase board or easel for visual cueing.

    b) Facilitators shall stand in the center of the circle.

    c) The topic shall be written on the dry erase board in order to reinforce its importance.

    d) Remember to ask questions of the group in order to encourage participation.

    e) Refrain from personal stories and dominating the discussion.

3) The basic structure of a therapeutic group shall include the following description with examples:

    a) **Group Orientation** to Date, Location, and Name of Group

        Today is ______ (day, month, date, year) and we are at Laguna Honda Hospital's Laguna Premier Club (LPC). This is our ________ (Wellness, Social, Thinking) group.

    b) **Introduction**: to encourage turn taking and working memory.

        (1) Use the passing of a ball or tossing a balloon to indicate each person's turn when introducing them self and sharing another bit of information about themselves (try to incorporate to relate to the day's topic).

            My name is_______ and (add another question to share about themselves) ________ (e.g., My favorite place I have ever lived is_______).

(2) Be patient and allow each person time to remember what was asked of them.

(3) Repeat any answers aloud for those who cannot or do not speak loud enough for the group to hear.

4) **Activity with Group Objective:** Goal to be achieved by group intervention.

i) Social Skills: to become more self-aware of behavior triggers through identifying emotions.

ii) Wellness: to improve health and well-being through skill based training.

iii) Thinking: to strengthen working memory through multi-modal techniques.

(1) Throughout the activity the objective, topic, or group activity is referred to in order to aid memory.

(2) Ask participants questions to encourage participation.

(3) Other staff present will be responsible for monitoring safety (i.e.: seating arrangements to prevent wandering and/or aggressive incidents), addressing issues with residents 1:1, verbal outbursts, redirecting, de-escalation or personal needs).

5) **Closing the Group Activity:**

(1) At the close of the activity, the facilitator summarizes the group objective and to remind participants of the context.

(2) Each resident is cued regarding their experience with use of a bouncing ball or balloon toss.

(3) Participants will be able to respond appropriately to questions based upon cognition and skill level.

(4) A relaxation exercise/deep breath is recommended to calm the resident before transport back to neighborhood.

(5) The next meeting time is discussed.

CHEST TUBE CARE AND MAINTENANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) may care for residents with an existing chest tube(s) for non-acute/non-pneumothorax diagnoses, such as pleural effusion or for drainage of empyema.

2. Chest tubes will not be inserted at LHH. If the resident requires the replacement of an existing chest tube(s), or the insertion of a chest tube(s) for an acute diagnosis, the resident must be transferred to an outside acute facility.

3. The Registered Nurse (RN), once demonstrating competence in this procedure, is responsible for ongoing maintenance, including but not limited to: chest tube site assessment, new dressing changes, checking for air leaks, checking for presence of subcutaneous air (crepitus), and changing drainage units.

4. The Licensed Vocational Nurse's (LVN) role in the management of chest tubes is to assist the RN with monitoring of chest tube output only, and reinforcement of an existing dressing (placing dressing over an existing dressing until a new dressing change can be performed by the RN).

5. Chest tubes may be clamped only as ordered by the physician and during the circumstances outlined in the procedure section.

6. For non-palliative care residents, vital signs will be assessed at a minimum of every 8 hours and as clinically indicated and chest tube output will be measured every 8 hours and as clinically indicated.

7. For palliative care residents, vital signs monitoring and chest tube output monitoring will be determined per individual basis and per physician order.

8. LHH will not perform chest tube irrigations, pleurodesis, or chest tube auto-transfusion.

9. Only a physician may remove a chest tube, and in the presence of a licensed nurse.

10. Two Curved Kelly clamps and two Xeroform gauze dressings must be kept at the resident's bedside at all times in case of emergency, as well as one back-up collection container.

11. The Admission Coordinator (non-South 3 admissions) or the South 3 Team will alert the Clinical Nurse Specialist when a resident with a chest tube(s) is to be admitted so needed supplies can be ordered.

PURPOSE:

To outline procedures to manage residents requiring a chest tube or drain, and drainage system.

BACKGROUND

1. Residents with chest tubes/drainage systems are at risk for air leaks or accidental disconnection of the tube(s) to the closed system resulting in spontaneous pneumothorax, subcutaneous air, and acute respiratory distress.

2. A chest tube with underwater seal drainage is used to drain air, blood, or fluid from the pleural space (i.e., pneumothorax, Hemothorax, large pleural effusion, empyema) so that the compressed lung will re-expand. This water seal prevents inadvertent lung collapse by acting as a one way valve.

3. Indications for chest tubes include the following:

a. To remove air, fluid, blood or purulent drainage from the pleural space and/or mediastinum.

b. To allow re-expansion of lung tissue thereby improving pulmonary function.

c. To resolve a mediastinal shift in the event of a tension pneumothorax.

d. To prevent infection or enhance the resolution of the infection.

4. It is important to know the size of the chest tube in order to plan for the correct fit with the collection device. Refer to the operative report, procedural report, or other reference documentation. The chest tube sizes typically are:

    a. For air evacuation #12-32 French (Fr)

    b. For blood evacuation, standard chest tube size is 36Fr

    c. Flor fluid evacuation (e.g., pleural effusion) #9-12Fr pigtail catheter placed via interventional radiology.

DEFINITIONS:

Pneumothorax - Occurs when air leaks into the space between your lungs and chest wall. This air pushes on the outside of the lung and can cause it to collapse.

Hemothorax -Collection of blood in the pleural space

Pleural Effusion -Is an abnormal amount of fluid around the lung. Because pleural effusions are usually caused by underlying medical conditions, symptoms of these conditions are also often present (i.e., heart failure, cancer metastasis, etc.).

Empyema - pus in the pleural space

Heimlich Valve - is a type of one-way valve that connects to the chest tube. The valve lets extra air and fluid out of the chest, allowing the lung to fully expand. This is often used in the outpatient and long-term care settings.

Subcutaneous Air (Subcutaneous Emphysema) - Subcutaneous emphysema occurs when air gets into tissues under the skin. This usually occurs in the skin covering the chest wall or neck, but can also occur in other parts of the body. Subcutaneous emphysema can often be seen as a smooth bulging of the skin. When a health care provider feels (palpates) the skin, it produces an unusual crackling sensation as the gas is pushed through the tissue.

PROCEDURE:

1. Equipment

a. The Admission Coordinator or the South 3 Team will alert the Clinical Nurse Specialist when a resident with a chest tube(s) is to be admitted so needed supplies can be ordered.

b. Due to several different types of manufacturers of chest tubes and collection containers, refer to specific supplies as outlined in the manufacturer's instructions.

c. The following items will be kept at the bedside:

    i. Curved Kelly Clamps (2)

ii. Gauze 4x4 dressings (2)

iii. Xeroform gauze dressings(2)

iv. Sterile water if using water seal collection container

v. Items as outlined in manufacturer's instructions unique to chest tube type (e.g., chest tube caps, drainage containers, occlusive dressings)

vi. Suction head and tubing if required to enhance drainage for water seal collection container

vii. Personal protective equipment

2. Assessment of Resident

a. The RN will perform a respiratory assessment/monitoring each shift including the following (the LVN may assist in data collection):

i. **Subjective Data**: pain assessment, activity tolerance, dyspnea, cough, or other subjective data appropriate to the respiratory system.

- Chest tube(s) can cause significant discomfort to the resident. A focus within the resident's plan of care should be on pain management.

- Assess for the need for premedication prior to mobility for resident's with chest tube(s).

ii. **Objective Data**: lung sounds, respiratory effort, respiratory rate, sputum color and consistency, palpating for subcutaneous air (crackling feeling under the skin which could suggest air leak), non-verbal signs of pain/discomfort in the resident who is unable to communicate pain, skin color, condition of dressing (drainage, adherence of dressing).

iii. **Monitoring of the chest tube collection device**: color and amount of drainage each shift, bubbling in the water suction chamber (if utilizing a water seal collection device), kinking of tubing, and flow of pleural fluid in tubing.

b. **Assessment of the chest tube insertion site during dressing changes**: color of skin, warmth at and around insertion site, drainage from site, pain/tenderness, condition of skin surrounding site, drainage on old dressing, resident's tolerance to the procedure.

c. Palliative care residents with a chest tube(s) will be assessed/evaluated per MD order.

i. The licensed nurse should target assessment to symptom management and ensuring that the chest tube is patent and draining.

3. Care and Maintenance

a. Standard precautions will be utilized during the care of resident's with chest tubes, or as determined by the physician and/or infection control nurse.

b. For non-palliative care patients, pleural fluid output will be monitored and documented every 8 hours and PRN.

i. For water seal collection containers, note the output by drawing a line on the container with the date/time for the corresponding output.

ii. For non-water seal collection containers, follow manufacturer's instructions for direction on measuring of output specific to device.

c. Change chest drainage system(s) when accidentally broken, cracked, or full, and per physician order.

i. Label the container when changing it with date and initials.

d. If a chest tube becomes disconnected from the collection container, clean the end with an alcohol wipe, reconnect to the collection container tubing, and secure the connection with tape.

4. Milking of Chest Tube(s) Procedure

a. Routine milking of chest tubes is not recommended, and may be necessary in cases of active bleeding to prevent blood clotting or other thick drainage in the tubing that would interfere with patency.

b. Perform milking of chest tube per physician order:

i. Start proximally near the chest tube insertion site, squeezing in short segments until reaching the distal end (near the drainage container).

ii. Stabilize the drainage tubing with one hand and slide the other hand from that point along the tubing away from the patient.

5. Clamping of Chest Tube(s)

a. A chest tube may be clamped when changing a water seal drainage unit.

b. Do not clamp for longer than one minute.

c. If the resident exhibits signs of respiratory distress, unclamp the tube and immediately contact the physician.

d. Clamp closest to the drainage unit, not closest to the resident, so the clamp can remain visible.

e. Manual clamping is preferable to the use of a curved Kelly clamp.

f. If a curved Kelly clamp must be used, place a thin piece of 4x4 gauze under the tips of the curved Kelly clamp to prevent cracking of the tube.

6. Special Consideration After Death

a. For medical examiner and autopsy cases, do not remove the chest tube or drainage container.

b. Otherwise, as part of post-mortem care, disconnect the chest tube and drainage container and dispose.

7. Documentation

a. Document vital signs in the LCR, including pain assessment.

b. Respiratory assessments and evaluation will be documented in the Interdisciplinary Progress Note. After dressing changes, document the condition of the chest tube site and tolerance to the procedure in the Interdisciplinary Progress Note.

c. The RN will document chest tube dressing change, change in chest tube collection container in the Treatment and Administration Record (TAR).

d. Activate and document on the Chest Tube Resident Care Plan (RCP) (see attached).

e. Document chest tube output on the TAR.

ATTACHMENT:

RCP of Chest Tube Management

REFERENCE:

CROSS-REFERENCE:
None.

Original adoption: 16/01/12

LHH DEPARTMENT OF PSYCHIATRY OVERVIEW

POLICY:

LHH Department of Psychiatry providers will comply with the following rules, procedures and protocols in providing behavioral health services to LHH residents, and give priority to the primary focus on medically necessary clinical services that meet the behavioral health needs of LHH residents.

PURPOSE:

To provide an overview of LHH Department of Psychiatry scope of services and to assure consistency and continuity of behavioral health services for LHH residents that meet regulations and standards and are in alignment with the mission and strategic goals of LHH, San Francisco Health Network Behavioral Health Services (SFHN-BHS) and SFHN.

PROCEDURE:

1. MISSION AND STANDARDS

LHH believes that high quality behavioral health services are essential for promoting the health, wellness and recovery of LHH residents. LHH Department of Psychiatry (the “Department”) is one of the Clinical Services of the LHH Medical Services and an integral part of the behavioral health service delivery system of the SFHN. In alignment with the mission and strategic goals of LHH, SFHN-BHS and SFHN, LHH Department of Psychiatry is charged with providing comprehensive, evidence-based and best practice behavioral health services to meet the behavioral health needs of LHH residents, and to support the Resident Care Teams’ (RCT) ongoing work with residents and their families.

Service delivery by the Department providers shall follow principles of Trauma Informed System of Care, Resident-Centered Communications, established and evidence-based practice guidelines, governing rules and regulations, billing and compliance standards and community standards of care.

The Department is committed to performance improvement by monitoring, evaluating and improving clinical care and operational processes to ensure that residents receive consistent high quality behavioral health services and to provide more effective program. The Department participates in LHH Hospital Wide Performance Improvement Program.

2. DEPARTMENT ORGANIZATION

LHH Department of Psychiatry consists of the following categories of staff: Psychiatrists (MDs), Psychologists (PsyDs/PhDs), Psychiatric Social Workers (LCSWs/ASWs), and other registered and/or privileged staff (e.g. registered substance use treatment counselors, privileged behavioral specialists).

The Chief of Psychiatry is responsible for all professional and administrative activities of the Department as defined in the LHH Medical Staff Bylaws. The Program Director is responsible for operational and supervisory duties for the comprehensive behavioral health program within the Department, as assigned by the Chief of Psychiatry. Members of the Department may be assigned by the Chief of Psychiatry to coordinate sub-services as dictated by clinical service and program needs.

Membership on the Medical Staff of LHH is a privilege which shall be extended only to those psychiatrists and psychologists who are professionally competent and continually meet the qualifications, standards, and requirements set forth in LHH Medical Staff Bylaws.

Staff providing mental health and substance use treatment services shall be credentialed through SFHN-BHS for pertinent service and billing privileges. Jointly with LHH Medical Staff Services and hospital leadership, SFHN-BHS provides oversight for programing, documentation and billing, compliance and quality assurance related to behavioral health services at LHH.

3. PROVIDER RESPONISIBILITIES

a. All providers of the Department of Psychiatry have responsibility for providing behavioral health services at LHH.

b. While individual providers may be assigned to provide certain services based on resident care and departmental operational needs, all providers must be able and willing to provide all services within the scope of his/her licensure, job description, and as defined by pertinent service and billing privileges (SFHN-BHS Mental Health Staffing Qualifications for Service and Billing Privileges, SFHN-BHS Substance Use Disorders Staffing Qualifications for Service and Billing Privileges).

c. All providers are responsible for aligning his/her performance objectives with departmental goals, LHH and SFHN-BHS strategic priorities, and the overall mission of SFHN.

d. All providers are responsible for following departmental, LHH and DPH rules and regulations, including but not limited to: administrative policies and procedures, documentation, billing and compliance.

e. All providers are responsible for meeting specified timely access and productivity standards for his/her clinical work.

f. All providers are to participate in performance improvement activities of the Department.

4. MEDICAL NECESSITY FOR CLINICAL SERVICES

a. Medically necessary clinical services for meeting the behavioral health needs of LHH residents are the primary service focus of the LHH Department of Psychiatry. All services that are billed to third parties must meet criteria for medical necessity.

The areas of medical necessity to be assessed and addressed by the Department providers include: Specialty Mental Health, Substance Use Treatment Services, Non-Specialty Mental Health, and Primary Care Behavioral Health. For details, see Attachment 1, Behavioral Health Medical Necessity.

b. It is the responsibility of the individual Department provider to ensure that all documentation for which billing is submitted meets the payer's definition of medical necessity. The determination of medical necessity should be supported by the provider's documentation of each service provided and billed. The Department provider shall discuss with the referring physician any service requests for non-medically necessary services, and give an explanation for why the request does not meet medical necessity criteria. The referring physician will be given an opportunity to modify his/her request to meet medical necessity criteria.

c. Services that are not medically necessary may be provided only under the following circumstances:
   i. Provision of such services are deemed beneficial for the residents and is in alignment with LHH strategic priorities
   ii. It has been determined that provision of such services will not compromise the provision of the medically necessary behavioral health services, and
   iii. Allocation of resources for such services has been approved by the Chief of Psychiatry in consultation with LHH medical and administrative leadership.

   Providers wishing to provide such services shall submit written requests and justification to the Chief of Psychiatry.

5. CLINICAL SERVICES DELIVERY

a. LHH Department of Psychiatry clinical services may be obtained through e-referrals or urgent and on-call mechanisms. Services to individual residents may be provided either on the LHH neighborhood or in the LHH Outpatient Clinic. Group services are provided in designated group space within LHH.

b. The following categories of clinical services are provided by the Department providers in order to meet the medically necessary behavioral health needs of LHH residents:
   i. Behavioral risk screening and e-referral triage
   ii. Psychiatric services (including consultation-only and referral-and-management)
   iii. Mental health services (including assessment, counseling, individual and group therapies, etc.)
   iv. Behavioral management (including behavioral consultation and planning, Laguna Honda Premier Club, Health and Behavior services)
   v. Neuropsychological and psychological assessment and testing
   vi. Substance Use Treatment and Recovery Services (STARS)

c. Documentation of behavioral health services is a crucial and integral part of the clinical service delivery by the Department. It is the responsibility of all clinical providers of the Department to:
   i. complete documentation of all clinical behavioral health services rendered in the health information system designated for the Department in a timely manner,
   ii. communicate findings and recommendations to the referring primary physician in a timely manner, and to document such communications in the medical record, and
   iii. meet documentation compliance standards for coding and billing purposes as required by the resident's payer(s) for behavioral health services and other pertinent rules/regulations.

6. NON-CLINICAL SERVICES

In addition to direct clinical services, LHH Department of Psychiatry staff may provide services that require behavioral health expertise to support the RCTs, other LHH departments and system-wide initiatives, in alignment with mission and strategic priorities of LHH, SFHN-BHS and SFHN. These may include (but are not limited to): committees and task forces, staff education, teaching and supervising trainees, performance improvement projects, and other organizational initiatives.

Requests for such services may be made to the Chief of Psychiatry. Decisions on whether departmental resources are allocated for such supportive services are made by the Chief of Psychiatry in consultation with LHH medical and administrative leadership. Individual providers may not provide non-clinical services without proper approval.

ATTACHMENT:

1. Behavioral Health Medical Necessity

REFERENCES:

1. LHH Medical Staff Bylaws
2. SFHN-BHS Mental Health Staffing Qualifications for Service and Billing Privileges
3. SFHN-BHS Substance Use Disorders Staffing Qualifications for Service and Billing Privileges
4. Title 9. CCR, Sections 1820.205, 1830.205, and 1830.210).
5. Department of Health Care Services Specialty Mental Health Diagnosis Outpatient Table
6. Department of Health Care Services Substance Use Disorder Diagnosis Table
7. Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Chapter 11. Medi-Cal Specialty Mental Health Services, Subchapter 1. General Provisions, Section 1810.247
8. SFHN-BHS Provider Manual
9. SFHN-BHS Substance Use Disorder Treatment Provider Manual.
10. LHH Policy HWPP 60-01. Performance Improvement Program

11. LHH Policy MSPP A01. LHH Department of Psychiatry Services

Most recent review: xx/xx/xx (Year/Month/Day)
Revised: xx/xx/xx
Original adoption: xx/xx/xx

Attachment 1

BEHAVIORAL HEALTH MEDICAL NECESSITY

Medicare defines "medical necessity" as "health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine" (https://www.medicare.gov/glossary/m.html). MediCal defines medical necessity in multiple areas of its regulations. SFDPH, Community Programs establishes criteria for Medi-Cal specialty mental health service eligibility in the California Code of Regulations, Title 9, Article 2. Provision of Services 1830.215.

The following areas of medical necessity are to be assessed and addressed by LHH Department of Psychiatry providers:

1. MediCal Specialty Mental Health

a. These are services provided to residents who meet the MediCal definition of medical necessity for Specialty Mental Health Services (per California Code of Regulations, Title 9, Article 2. Provision of Services, Sections 1820.205, 1830.205, and 1830.210, and Department of Health Care Services Specialty Mental Health Diagnosis Outpatient Table). These services are expected to be the most common type of services delivered by the Department. To meet eligibility for specialty mental health services, i-iii must be met:

   i. The resident must have a mental health condition that meet diagnostic criteria for one or more of the covered diagnoses by MediCal.

   ii. In addition to a covered diagnosis, the resident must have at least one of the following functional impairments that is the result of the covered mental health diagnosis: 1) significant impairment in an important area of life functioning, or 2) a reasonable probability of significant deterioration in an important area of life functioning.

   iii. The proposed services must be comprised of interventions that are aimed specifically at addressing the identified impairments, reflective of good clinical practice, and expected to:

   - significantly diminish the impairment or
   - prevent significant deterioration in an important area of life functioning.

   The impairments would not be responsive to physical health care based treatment.

b. At LHH, Medi-Cal Specialty Mental Health services include: psychiatry services, mental health services, behavioral management, neuropsychological assessment and testing. These services are comparable to those described in SFDPH Policy and in California Code (Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Chapter 11. Medi-Cal Specialty Mental Health Services, Subchapter 1. General Provisions, Section 1810.247; SFHN-BHS Provider Manual).

2. Substance Use Treatment Services

As with mental health specialty services, substance use assessment and treatment services are an integral part of a comprehensive behavioral health services continuum. As such, substance use treatment services are also a primary focus for the LHH Department of Psychiatry. These services are provided by LHH Department of Psychiatry STARS (Substance Treatment And Recovery Services) clinical staff to residents diagnosed with a substance use disorder based on the current Diagnostic and Statistical Manual (DSM) of Mental Health Disorders. Also see Department of Health Care Services Substance Use Disorder Diagnosis Table.

The substance use treatment services at LHH are modeled on requirements set forth by the California Drug MediCal Outpatient Drug Free program. Services include: assessment, treatment plan development, individual and group counseling, diagnosis, crisis intervention and medication consultation (see SFHN-BHS Substance Used Disorder Treatment Provider Manual).

3. MediCal Non-Specialty Mental Health

Non-Specialty mental health services are provided by LHH Department of Psychiatry clinical staff to residents who have diagnoses not covered in the Specialty Mental Health medical necessity criteria and/or have only mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a diagnosis defined by the current Diagnostic and Statistical Manual of Mental Health Disorders and covered by the payer.

Non-Specialty Mental Health services include mental health assessment, individual and group mental health treatment, psychological and neuropsychological testing, behavioral management, psychiatric consultations, psychotropic medication management, and certain outpatient services to include laboratory tests, drugs, supplies, supplements.

4. Primary Care Behavioral Health

Primary care behavioral health services are those services provided by LHH Department of Psychiatry staff to residents who have a primary diagnosis other than mental health or substance use. Primary care behavioral health services are directed towards modifying or resolving behavioral issues or illness management issues that are interfering with the resident's physical health recovery and/or movement to lower levels of medical care. Primary care behavioral health services are also used to provide information about brain functioning that directly impacts health management of residents.

Primary Care Behavioral Health services include Health and Behavior assessment and intervention services, psychological and neuropsychological assessment and testing, behavioral management consultations or plans, and/or psychotropic medication consultation and management.

Approved: (Year/Month/Day)
Revised: N/A

VALUE, MISSION AND VISION STATEMENTS

PURPOSE:

To define Laguna Honda Hospital and Rehabilitation Center's overall purpose as a part of the San Francisco Health Network and the San Francisco Department of Public Health (DPH) safety net.

VALUE:

1. ***Resident Centered Care:*** Everyone is dedicated and has a part to play in delivering resident centered care.
2. ***Compassion:*** We treat everyone as individuals deserving of respect and dignity.
3. ***Professionalism:*** We provide culturally competent evidence-based resident care with compassion and respect.
4. ***Competency:*** All staff will be qualified and trained for their respective disciplines upon hire and will maintain standards and quality of care.
5. ***Teamwork:*** Everyone is willing to learn and work together to achieve our Laguna Honda Campus goals.
6. ***Collaboration:*** With effective and respectful communication and coordination, we work as a team to achieve common goals.
7. ***Integrity:*** We foster an environment of honest, open interactions between all members of the Laguna Honda Community.
8. ***Communication:*** We promote respectful, sensitive, constructive and positive communication.

~~Our Residents come first.~~

MISSION:

We provide a welcoming, therapeutic and healing environment that promotes the individual's health and wellbeing.
~~To provide high quality, culturally competent rehabilitation and skilled nursing services to the diverse population of San Francisco.~~

VISION:

Building healthier lives as the leader in post-acute care.

~~To be an innovative world-class center of excellence in long-term care and rehabilitation.~~

Laguna Honda Hospital and Rehabilitation Center is an integral component of the San Francisco Department of Public Health.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

The San Francisco Department of Public Health shall:

1. Assess and research the health of the community.

2. Develop and enforce health policy.

3. Prevent disease and injury.

4. Educate the public and train health care providers.

5. Provide quality, comprehensive, culturally-proficient health services.

6. Ensure equal access to all.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 94/08/15, 99/01/06, 00/03/23, 07/10/29, 07/12/04, 09/10/27, 16/01/12 (Year/Month/Day)
Original adoption: 92/05/02

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

POLICY:

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

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

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

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

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

6. A standardized formatting template shall be utilized for hospital-wide policies and procedures (refer to LHHPP File: 01-11).

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

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

PURPOSE:

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

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

CHARACTERISTIC:

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

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

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

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

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

PROCEDURE:

1. Hospital-wide Policies and Procedures (LHHPP)

a. New LHHPP may be generated by:

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

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

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

    i. Chair of Nursing Executive Committee (NEC)
    ii. Chair of Medical Executive Committee (MEC)
    iii. Chief Medical Officer
    iv. Administrative designee (as determined by the Director of Quality

Management), for coordination purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

s. The LHHPP Website:

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

t. Manuals: A hard copy LHHPP Manual will be available in case the SFHN Intranet is disrupted.

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

2. Departmental Policies and Procedures (DPP)

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

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

c. Department Heads are responsible for:

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

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

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

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

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

f. Approval Process for DPP

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

g. Implementation of DPP

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

3. List of Minor Revisions Not Subject to JCC Approval

a. Refinements to formatting and layout;

b. Correction of typographical errors;

c. Correction of grammar and punctuation;

d. Changes to procedure titles;

e. Renumbering of policies and procedures;.

e. f. Informational updates to appendices (e.g. names of personnel, contact numbers, name of vendor(s), etc.)

ATTACHMENT:
None.

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

Revised: 08/07/22, 10/08/24, 10/12/03, 13/05/28, 13/09/24, 15/07/14, 16/01/12
(Year/Month/Day)
Original adoption: 92/05/20

COMMITTEES – MANDATED

POLICY:

~~The Hospital will~~Laguna Honda Hospital (Laguna Honda) shall establish Committees that are mandated by law or regulation.

PURPOSE:

To comply with regulatory requirements and assure effective operation of ~~Hospital~~ Laguna Honda committees.

PROCEDURE:

1. The facility shall have at least the following committees: Patient/Resident Care Policy and Procedure Review, Infection Control, ~~Pharmaceutical Service~~Pharmacy and Therapeutics and Performance Improvement and Patient Safety (PIPS) compliance ~~Quality Assessment and Assurance~~ as required by State and Federal regulation, and other committees as written in the Medical Staff by-laws.

2. The committees shall be composed of membership from the areas of administration, medicine, nursing, pharmacy and other representatives as required by regulation and written in the Medical Staff by-laws.

3. The Patient/Resident Care Policy and Procedure Review Committee shall meet at least annually, while the Infection Control Committee, Pharmacy and Therapeutics ~~Pharmaceutical Service~~ and PIPS ~~Quality Assessment and Assurance Committee~~ shall meet at least quarterly. Medical staff committees shall meet as frequently as written in the Medical Staff by-laws.

4. Minutes of all committees shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken. Meeting minutes shall be submitted to the Secretary of the Medical Executive Committee as stated in the medical staff by-laws.

5. ~~The committee chairperson shall be held accountable for the committee functional compliance with governing authority.~~Functions of the respective committees shall be outlined in policies and procedures and or described in the medical staff by-laws.

ATTACHMENT:
None.

REFERENCE:
Medical Staff By-laws, Title 22

Revised: 07/12/04, 09/10/27, 16/01/12 (Year/Month/Day)

Original adoption: 92/05/20

DEPARTMENTAL RESPONSIBILITY AND ACCOUNTABILITY

POLICY:

1. Departments/services at Laguna Honda Hospital and Rehabilitation Center (LHH) shall operate according to written policies and procedures, standards, or plans.

2. The procedures outlined in this policy describe the procedural responsibilities and accountability of each department/service to ~~the medical and administrative staff~~LHH.

PURPOSE:

To meet State, Federal and City regulatory and legal requirements that govern ~~departmental~~ services or functions of the department.

PROCEDURE:

1. Develop and establish written plans that describe or illustrate the following information:

    a. Organizational and reporting structure

    b. Job descriptions and departmental responsibilities

    c. Licensure requirements, if applicable

    d. Policies and procedures that meet or support the hospital's

        i. Strategic goals, vision, mission, core competencies, and values,

        ii. Performance improvement goals or initiatives,

        iii. Infection control standards, or

        iv. Patient safety plan

2. Develop departmental/service policies and procedures that meet State, Federal and City regulatory requirements.

3. Submit departmental/service policies and procedures that impact clinical care services (e.g. dietetic services) for review and approval by the Nursing Executive, Medical Executive, and Hospital Executive~~Medical, Executive and Nursing Executive~~ Committees prior to implementation and review and approval by the hospital's governing body.

4. Assign departmental/service staff to participate in performance improvement, infection control, or patient safety committees organized by medical or administrative staff.

5. Department managers are responsible for working collaboratively and consulting with appropriate health professionals and administration.

~~5.~~6. Department managers are responsible for updating departmental/service policies and procedures on the LHH intranet for their department/service and within their policy and procedure binder.

ATTACHMENT:
Appendix A: List of Laguna Honda Hospital and Rehabilitation Center Departments and Services

REFERENCE:
Title 22 General Acute Care Hospitals

Revised: ~~N/A~~16/01/12 (Year, Month, Day)
Original adoption: 10/12/01 ~~(Year/Month/Day)~~

Appendix A: List of Laguna Honda Hospital and Rehabilitation Center Departments and Services

1. Activity Therapy
2. Admissions & Eligibility
3. Central Supply
4. Environmental Services
5. Facility Services
6. Health & Safety and Emergency Management
7. Health Information Services
8. Infection Control
9. Laboratory Services
10. Materials Management
11. Medical Staff
12. Nursing Services
13. Nutrition Services
14. Nutrition Services/ Clinical Nutrition – Diet Manual
15. Outpatient Clinics
16. Pharmacy Services
17. Radiology
18. Rehabilitation Services
19. Respiratory Services
20. Social Services
21. Spiritual Care
22. Volunteers Services

ABUSE PREVENTION, IDENTIFICATION, INVESTIGATION AND RESPONSE

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall promote an environment that enhances resident well-being and protects residents from abuse and neglect.

POLICY:

1. Laguna Honda employees and volunteers shall strive to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect.

2. Laguna Honda employees and volunteers shall comply with their obligation under law to refrain from acts of abuse or neglect and to report observed or suspected incidents of abuse and neglect.

3. Laguna Honda employees and volunteers shall respond to these incidents in a timely manner and report the incident to their direct supervisor, nurse manager or supervisor.

4. Laguna Honda Department Managers ~~will be~~are responsible for monitoring staff compliance with this policy and Laguna Honda Quality Management and Human Resources departments shall be responsible ~~the~~ for the process oversight.

5. Retaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

PURPOSE:

1. To protect the resident from abuse or neglect

2. To report incidents of abuse or neglect without fear of retaliation and in a timely manner

3. To promptly investigate ~~all~~ allegations of abuse or neglect

4. To provide clinical intervention to prevent and minimize abuse or neglect

5. To meet reporting requirements as mandated by federal and state laws and regulations

DEFINITION:

1. Abuse means “the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." (42 CFR 488.301) All residents, even those in a coma, may experience physical harm, pain or mental anguish. Abuse can include verbal, sexual, physical, financial and mental abuse.

   a. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

   b. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

   c. Physical abuse~~, but is not limited to, includes~~includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

   ~~c.~~d. Financial abuse ~~includes but~~includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.

   ~~d.~~e. Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.

2. Neglect means “failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.” (42 CFR 488.301)

3. Misappropriation of resident property means “the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.” (42 CFR 488.301)

4. Involuntary s~~S~~eclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room against the residents’ will, or the will of legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident’s needs.

5. Injury of unknown source/~~-~~origin is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point ~~of~~ in time or the incidents of injuries over time are suspicious in nature.

6. Serious bodily injury [as defined in Section 6703 (b) (3) of the Affordable Care Act] is defined as an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

i. ~~All~~ A~~a~~pplicants for employment at Laguna Honda must submit to fingerprinting by federal authorities and must have a clear background check prior to ~~the~~ processing of any appointments for hire at Laguna Honda. This is required in addition to the existing bi-annual fingerprinting and background check process in the State of California for initial certification and continued CNA certification as a condition of employment

b. Experience and References

i. Applicants for employment shall provide a photocopy of certification and verification (including references) of qualifying experience. The facility will make reasonable efforts to verify previous employment and to obtain information from previous ~~or/ and~~and/or current employers.

2. Education

a. Employee and Volunteer Education

i. ~~All~~ N~~n~~ew employees/~~-~~volunteers, including transfers or~~and~~ inter- ~~departmental~~ facility reassignments ~~within~~ to Laguna Honda, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement" shall be kept in the employee's/ volunteer's personnel file.

ii. ~~All~~ N~~n~~ew employees/ volunteers, including transfers ~~and~~ or inter-~~departmental~~ facility reassignments ~~within~~ to Laguna Honda, shall, as a condition of employment, participate in "The Abuse Prohibition/Prevention Program", which includes the following:

- Facility orientation program on residents' rights, including confidentiality, preservation of dignity, recognizing and reporting of

abuse without fear of retaliation, lost/stolen property, and misappropriation of resident funds;~~.~~

- SMART training provided to ~~all~~ new Laguna Honda staff;

- Review of the following policies and procedures that support the overall program:

- LHHPP 22-03 Resident Rights
- LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
- LHHPP 22-08 Threats of Physical Violence to Residents
- LHHPP 24-06 Resident Suggestions and Complaints
- LHHPP 22-10 Management of Aggression and Hostility
- ~~LHHPP B 3.0 Nursing Policy - Resident Funds~~
- LHHPP ~~76-04~~ 73-05 Violence in the Workplace-Zero Tolerance

- Annual in-service education provided by the ~~Department of Education and Training (DET)~~ Quality Management Nurse Educators to all employees, which includes a review of residents' rights, abuse prohibition/prevention, and resident and employee freedom from retaliation when reporting abuse allegations.

- ~~DET~~ Nursing Education provides additional abuse prevention training to all nursing staff, including recognition of potential signs of abuse including catastrophic reactions in residents, and recognition of factors that may contribute to abuse such as employee stress and burnout.

~~Employees shall be notified of their reporting obligations~~ Employees are obliged to report any reasonable suspicion of ~~a crime~~ abuse against a resident to a law enforcement agency~~cy.~~. Employees shall be notified of their reporting obligations during the new employee orientation and annually during residents' rights and abuse prevention in-services.

b. ~~Employees shall be notified of their reporting obligations~~ ~~dduring the new employee orientation and annually during residents' rights and abuse prevention in-services~~. Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident to a law enforcement agency during the new employee orientation and annually during residents' rights and abuse prevention in-services.

Information on employee rights, including employee rights including the right to file a complaint with the State Survey Agency if anyone at the facility retaliates against an employee who files a report of a reasonable suspicion of ~~a crime abuse~~ a crime committed against a resident of the facility to a law enforcement agency, shall be posted in the Human Resources Department. Posting will also

encourage the employee to file a complaint with the Human Resources Department in the event of retaliation. ~~Information on employee rights shall be posted in the Human Resources Department. Posting will also encourage the employee to file a complaint with the Human Resources Department in the event of retaliation.~~

c.

~~Information on employee rights , shall be posted in the Human Resources Department.~~

~~c. Posting will also encourage the employee to file a complaint with the Human Resources Department in the event of retaliation.~~

d. Resident Education

   i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

   ii. A listing of Resident~~'s~~s' rights shall be posted on each unit.

3. Prevention

a. Staff and families are provided with information on how and whom they may report concerns, incidents and grievances (see Employee and Volunteer Education).

b. Staff ~~assigned to the high-risk unit must be appropriately~~ shall be trained in Safety Management and Response Technique (SMART) techniques, which includes components on dealing with residents' aggressive behavior and catastrophic reactions.

c. ~~The~~ Staff conduct resident assessments, ~~and provide the~~develop care plans, and monitor residents needs and behaviors that may lead to neglect or abuse ~~, care planning and monitoring of residents with needs and behaviors that may lead to neglect or abuse~~ (see "Resident Assessment and Care Planning").

4. Identification: Signs of Possible Abuse

a. The following signs may alert Laguna Honda staff to possible resident abuse and indicate the need for immediate and further investigation:

   i. Statements from a resident alleging abuse (including unreasonable confinement) by staff or another resident;~~.~~

   ii. Sounds that suggest physical or verbal abuse;~~.~~

iii. Repeated resident "accidents," unexplained contusions or abrasions, injuries or bruises of unknown origin in a suspicious location;~~.~~

iv. Illogical accounts given by resident or staff member of how an injury occurred;~~.~~

v. Changes in resident personality or behavior, such as from pleasant to angry or from even-tempered to dejected or depressed; from easy-going to anxious, especially around a certain person, and especially if reluctant to give information;~~.~~

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;~~.~~

vii. Resident-to-resident altercations.

5. ~~Staff/Volunteer Intervention~~~~Investigation and Protection~~Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer

i. Observes abuse,
ii. Suspects that abuse has occurred,
iii. Observes resident~~-~~–to~~-~~-resident altercation,
iv. Identifies an injury of unknown source/ origin,
v. Learns about an allegation of abuse or neglect of any Laguna Honda resident, and/or is the first person to learn of a resident-to-resident altercation. that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.
~~vi. Is the first person to learn of a resident-to-resident altercation,~~

~~that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.~~

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:~~:~~ ~~by:~~

i. In the event of alleged employee to resident abuse, ~~by~~ the responsible manager shall reassign~~ing~~ the employee who is being investigated to non-patient care duties or place~~ing~~ the employee on administrative leave~~,~~ if non-patient care duties are not available at the point the manager was notified of the allegation. These measures ~~will~~ shall be in place until the investigation is completed.

ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separat~~inge~~e the residents and ~~re~~move ~~ing~~ eeach resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

~~c.~~ The responsible manager shall document the incident in respective ~~the~~ each involved resident'ss~~'~~ medical record.~~s~~ and develop or revise care plan as necessary. ~~(including both residents when the incident involves a resident- to-resident altercation) and initiate a care plan update for each resident as necessary.~~

~~d.~~c.

~~e.~~d. Upon receiving a report of alleged abuse, the attending or on-call physician shall promptly perform a ~~focused history and~~ physical exam. The physician shall record in the progress notes of the resident's medical record the history of abuse as relayed, any findings of physical examination and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a ~~focused history and~~ physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

~~f.~~ The Medical Social Services Worker ~~will~~ shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

~~g.~~

f. The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".

6. Reporting Protocol

a. The facility mandates all staff to report suspected abuse to the local Ombudsman office as required by State law.

b. The facility requires the employee, manager, agent or contractor of the facility to report to the Sheriff's Department any reasonable suspicion of a crime committed against a resident of Laguna Honda Hospital.

i. If the criminal incident resulted in serious bodily injury to the resident, the Sheriff's Department must be notified immediately, no later than 2 hours after the suspicion is formed.

ii. Criminal incidents not resulting in serious bodily injury to the resident ~~must~~ be reported to the Sheriff's Department within 24 hours of the time the suspicion is formed.

c. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform ~~each other~~one another ~~or ensure each other has been informed~~ of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker;

iii. Notify within 24 hours the Medical Social Services Worker and Quality Management by phone or e-mail.

d. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

e. If an abuse allegation involves a Laguna Honda staff person, the nursing supervisor shall notify Human Resources and the staff person's immediate supervisor within 24 hours.

f. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician, the San Francisco Sheriff's Department, ~~or~~and the Laguna Honda Administrator On Duty.

g. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of staff to resident abuse, resident to resident altercations, including ~~the~~ altercations that occur between two residents with dementia ~~and~~ that do not result in ~~serious~~ bodily injury or rise to a reasonable suspicion of a crime, and ~~shall~~ determine, ~~in consultation with a Deputy Sheriff if necessary~~, if an incident is reportable to the Sheriff's Department. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff’s Department.

~~h. The nurse manager or nursing supervisor shall assess on a case-specific basis the incidents of verbal abuse that do not result in serious bodily harm or rise to a reasonable suspicion of a crime, and shall determine, in consultation with a Deputy Sheriff if necessary, if an incident is reportable to the Sheriff's Department.~~

~~I~~ h. In cases of alleged or factual rape the following steps must be taken:

i. Facility staff must immediately notify the San Francisco Sheriff's Department (Ext. 4-2319; 4-2301)

ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

iii. At the San Francisco Rape Treatment Center the resident will be interviewed, specimens will be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.

v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

Ji. . This policy designates the Director of Quality Management as the primary mandated reporter for Laguna Honda Hospital and Rehabilitation Center (Laguna Honda). The Director of Quality Management or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff's Department, and the California State Licensing and Certification Office.

Kj. . The results of the investigation must shall be reported to the State Survey and Certification Agency within five days of the incident. If the alleged violation is verified, appropriate corrective actions must be taken.

l.k. The respective department head, in consultation with Human Resources, will shall report all cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards

ii.

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse allegation involves a Laguna Honda employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or shall immediately place the employee on administrative leave, pending completion of the full investigation. The interim reassignment or administrative leave will be in place until the Nursing and Human Resources Departments complete their investigations and confer on their findings. The employee willshall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation involves a Laguna Honda employee and the preliminary investigation does support the allegation, the manager ~~will~~ shall continue the administrative leave measure pending completion of the full investigation by the Human Resources Department. The investigating supervisor/manager may consider the following factors in determining whether the ~~accused~~ alleged employee ~~should~~ shall be placed on leave or reassigned to non-patient care duties:
   i. Severity of the allegation,
   ii. Circumstances of the case per the investigation, and
   iii. Prior disciplinary and employment history.

d. The Department of Quality Management shall forward ~~all~~ investigation documents related to the abuse allegation ~~s~~ involving Laguna Honda staff to the Laguna Honda Department of Human Resources. The Laguna Honda Human Resources Department shall conduct an independent investigation of any abuse allegation involving Laguna Honda staff whenever the investigating party determines in the Summary of Alleged Abuse Preliminary Report form that abuse is substantiated.

e. Laguna Honda Human Resources Department shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

f. ~~Laguna Honda Human Resources Department shall review all confirmed substantiated cases of resident abuse with the Deputy City Attorney~~. If an employee or non-employee is identified as a suspect, the nursing supervisor or nurse manager shall contact the Sheriff's Department. The nursing supervisor or manager and the Sheriff's Department shall jointly carry out the investigation and initiate action to protect the resident.

~~h.~~g. The nurse manager or nursing supervisor ~~will inform~~shall inform the resident and responsible party of the findings of the investigation and ~~will~~ provide a feedback to the employee who reported abuse allegation.

~~**6. Reporting Protocol**~~

~~a. The facility mandates all staff to report suspected abuse to the local Ombudsman office as required by State law.~~

~~b. The facility requires the employee, manager, agent or contractor of the facility to report to the Sheriff's Department any reasonable suspicion of a crime committed against a resident of Laguna Honda Hospital.~~

i. If the criminal incident resulted in serious bodily injury to the resident, the Sheriff's Department must be notified immediately, not later than 2 hours after the suspicions is formed.

ii. Criminal incidents not resulting in serious bodily injury to the resident must be reported to the Sheriff's Department within 24 hours from of the time the suspicion is formed.

c. The nurse manager, charge nurse, and nursing supervisor shall inform each other or ensure each other has been informed of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker;

iii. Notify within 24 hours the Medical Social Services Worker and Quality Management by phone or e-mail.

d. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

e. If an abuse allegation involves a Laguna Honda staff person, the nursing supervisor shall notify Human Resources and the staff person's immediate supervisor within 24 hours.

f. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician, the San Francisco Sheriff's Department, or the Laguna Honda Administrator On Duty.

g. The nurse manager or nursing supervisor shall assess on a case-specific basis the altercations that occur between two residents with dementia and do not result in serious bodily injury or rise to a reasonable suspicion of a crime, and shall determine, in consultation with a Deputy Sheriff if necessary, if an incident is reportable to the Sheriff's Department.

h. The nurse manager or nursing supervisor shall assess on a case-specific basis the incidents of verbal abuse that do not result in serious bodily harm or rise to a reasonable suspicion of a crime, and shall determine, in consultation with a Deputy Sheriff if necessary, if an incident is reportable to the Sheriff's Department.

i. In cases of alleged or factual rape the following steps must be taken:

~~i. Facility staff must immediately notify the San Francisco Sheriff's Department (Ext. 4-2319; 4-2301)~~

~~ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.~~

~~iii. At the San Francisco Rape Treatment Center the resident will be interviewed, specimens will be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.~~

~~iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.~~

~~v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.~~

~~j. This policy designates the Director of Quality Management as the primary mandated reporter for Laguna Honda Hospital and Rehabilitation Center (Laguna Honda). The Director of Quality Management or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff's Department, and the California State Licensing and Certification Office.~~

~~k. The results of the investigation must be reported to the State Survey and Certification Agency within five days of the incident. If the alleged violation is verified, appropriate corrective actions must be taken.~~

~~l. The respective department head, in consultation with Human Resources, will report all cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards~~

~~ii.~~

~~c. The nurse manager or charge nurse or nursing supervisor shall:~~

~~i. Immediately notify the attending or on-call physician and the nursing supervisor of the alleged abuse~~

~~ii. Immediately inform the resident/ surrogate decision-maker that the abuse allegation is being taken seriously, identify for the resident steps being taken to provide for the resident's safety, and assure the resident that an investigation is being conducted and that the outcomes of the investigation will be reported to the resident/surrogate decision-maker.~~

~~iii. Notify the Medical Social Services Worker and Quality Management by phone or e-mail of all reports of alleged abuse within 24 hours.~~

~~iv. If the resident has decision-making capacity and gives permission, physician or the nurse manager may contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.~~

~~v. If an abuse allegation involves a Laguna Honda staff person, the nursing supervisor shall notify Human Resources and the staff person's immediate supervisor within 24 hours.~~

~~vi. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician, or the San Francisco Sheriff Department, or the Laguna Honda Administrator on Duty.~~

~~vii. The nurse manager or nursing supervisor shall assess on a case specific basis if a resident to resident altercation between two residents with dementia, that does not result in serious bodily harm or rise to a reasonable suspicion of a crime, is reportable to the Sheriffs Department and may consult with sheriff officers in determining reportability.~~

~~viii. The nurse manager or nursing supervisor shall assess on a case specific basis if an incident of verbal abuse, that does not result in serious bodily harm or rise to a reasonable suspicion of a crime is reportable to the Sheriffs Department and may consult with sheriff officers in determining reportability.~~

~~d. In cases of alleged or factual rape, the facility staff must immediately notify San Francisco Sheriff Department (ext. 4-2319 or 4-2301). The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A - 25th Street, San Francisco (821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects. At the San Francisco Rape Treatment Center, the resident will be interviewed, specimens taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate. In all cases of rape, the attending physician shall request a psychiatric consultation for the resident.~~

~~e. If a non-employee is identified as a suspect, the nursing supervisor or nurse manager shall contact the Sheriff's Department.~~

~~f. This policy designates the Director of Quality Management as the primary mandated reporter for Laguna Honda Hospital and Rehabilitation Center (Laguna Honda). The Director of Quality Management/designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriffs Department, and to the California State Licensing and Certification office.~~

~~g. The results of the investigation must be reported to the State survey and certification agency within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.~~

~~h. The respective department head, in consultation with Human Resources, will report all cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards and/or agencies.~~

~~7.~~8. Forms Completion and Submission

a. The reporting employee shall complete the ~~"~~Unusual Occurrence r~~R~~eport~~ing" form~~ and "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), or designate the Medical Social Worker to complete form SOC 341. Both reports must be submitted to the Department of Quality Management. (Refer to Laguna Honda ~~Forms web~~ designated site for copies of electronic forms related to Abuse Investigation).

b. The investigating supervisor/manager conducting the ~~inquiry~~ investigation into resident abuse or neglect shall ~~assure~~ verify that the Unusual Occurrence and Report of Suspected Dependent Adult/Elder Abuse forms ~~are~~ have been completed and ~~forwarded~~ submitted to the Department of Quality Management.

~~b.~~c. The SOC 341 shall be faxed to 415-751-9789 by the reporting employee and the fax verification ~~sent~~submitted to Quality Management Department.

~~c.~~d. In cases of resident-to-resident altercation, the investigating supervisor/manager shall complete the "~~Summary of Resident-to-Resident Altercation Preliminary Inquiry"~~ "Abuse Preliminary Inquiry Form-Resident to Resident" form and ~~forward~~ submit the form, along with any attachments, to the Department of Quality Management.

e. In cases of alleged resident abuse by staff or visitor, the investigating ~~supervisor~~director/ manager conducting the inquiry shall complete a "~~Summary of Alleged Abuse Preliminary Inquiry~~ "Abuse Preliminary Inquiry Form-Staff to Resident" form or "Abuse Visitor to Resident Abuse Investigation" form and ~~forward forward~~ submit the form, along with any attachments to the Department of Quality Management. Final conclusion is determined by the Nursing Director.

~~d.~~f. In cases of injury on unknown origin, the investigation supervisor/manager shall complete the "Abuse Preliminary Inquiry Form - Injury of Unknown Origin" form and submit the form, along with any documents, to the Department of Quality Management.

g. Quality Management staff shall submit~~ — F~~form SOC 341 to the Ombudsman Office via fax (415-751-9789) when fax verification by the reporting employee is

not received by the Quality Management Department staff. ~~and provide a copy to the Sheriffs Department~~

~~e.~~h. Quality Management staff shall provide a copy of the form SOC 341 to the Sheriff's Department.

~~8.~~9. Resident Assessment and Care Planning

a. In cases of allegations of abuse or resident-to-resident altercation, the nurse manager or charge nurse, with input from other RCT members, shall take the lead in assessing and updating the residents care plan(s). ~~Questions~~ Considerations ~~pertinent to~~ for care planning ~~to minimize or prevent abuse or resident-to-resident altercations~~ may include the following:

i. ~~What~~ S~~s~~hort-term and long-term measures ~~need to be taken in order~~ to provide the resident with a safe and secure environment~~?~~.

ii. ~~What~~ M~~m~~easures ~~need to be taken~~ to mitigate the psychological impact of the incident~~?~~.

iii. ~~What~~ Identify C~~c~~haracteristics, behaviors or habits that make the resident vulnerable at risk for aggression or ~~prone to abuse or~~ altercations~~?~~ .

iv. ~~Was there a~~ P~~p~~hysiologic factor(s) involved in this incident~~?~~. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain~~,~~? Did the ~~resident have~~resident have signs of an infection or delirium?~~)~~

v. ~~Is the resident currently receiving~~ T~~t~~reatment that may have contributed to his/her behavior~~?~~.

vi. ~~Does the resident~~ N~~n~~eed ~~an urgent~~ for psychiatric evaluation.~~?~~

vii. ~~Was there an~~ E~~e~~nvironmental stimulus/factor(s) contributing to ~~in~~ this incident (excessive noise, crowded room).~~?~~

viii. ~~Can the environment be modified?~~ Ability to modify environment.

ix. ~~What is the~~ L~~l~~ikelihood of a repeat incident~~?~~.

x. ~~What~~ What I~~i~~nterventions ~~can to~~ can be implemented to minimize the risk of recurrence~~?~~.

xi. ~~Does the resident~~ N~~n~~eed ~~to be relocated or transferred~~ relocation or transfer ~~from the facility~~ to another level of care~~?~~.

~~b. In cases where there is an allegation or finding of involuntary confinement, the nurse manager or charge nurse, with input from other RCT members, shall take the lead in assessing and updating the residents care plan(s).~~

~~c. The RCT members must review the confinement to ensure it is not involuntary except when it is a permitted emergency or short term monitored separation from other residents for a limited period of time (suggest no greater than 24 hours) used as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs. Involuntary confinement that does not meet this provision must be immediately terminated.~~

~~d. If the RCT determines confinement is necessary to ensure the resident's well-being, and/or the well-being of other residents, this confinement must be voluntary and may only be implemented upon assessment of the following factors by the RCT members:~~

~~i.~~xii. ~~What is the~~ P~~purpose of the stated restriction~~.~~?~~

~~ii.~~xiii. ~~What~~ S~~specific behavior is being treated through the application of a restriction?~~.

~~iii.~~xiv. ~~What~~ O~~other, less restrictive measures~~ that ~~have been tried previously that have been unsuccessful in achieving the desired outcome?~~.

~~iv.~~xv. ~~Are there~~ O~~other less restrictive measures~~ for consideration ~~that could be tried again or that have not been previously tried, that could achieve the same or similar outcome?~~.

~~v.~~xvi. ~~How will the~~ Evaluation on the ~~effect of the restriction~~. ~~be evaluated?~~

~~vi.~~xvii. ~~Does the~~ R~~resident consent to the restriction?~~.

~~9. Investigation~~

~~a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation~~, or allegation of ~~or abuse, shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).~~

~~b. If an abuse allegation involves a Laguna Honda employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or shall immediately place employee on administrative leave, pending completion of the full investigation. The interim reassignment or administrative leave will be in place until the Nursing and~~

~~Human Resources Departments complete their investigations and confer on their findings. The employee will be formally notified of the outcome of the investigation and future employee assignment.~~

~~c. If an abuse allegation involves a Laguna Honda employee and the preliminary investigation does support the allegation the manager will continue administrative leave measure pending completion of the full investigation by the Human Resources Department. The investigating supervisor/manager may consider the following factors in determining whether the accused employee should be placed on leave or reassigned to non-patient care duties: severity of the allegation:~~

~~d.~~

~~i. Severity of the allegation~~,
~~ii. Circumstances of the case per the investigation~~, and
~~iii. Prior disciplinary and employment history~~.

~~e. The Department of Quality Management shall forward all abuse allegations involving Laguna Honda staff to the Laguna Honda Department of Human Resources. The Laguna Honda Human Resources Department shall conduct an independent investigation of any abuse allegation involving Laguna Honda staff whenever the investigating party determines in the Summary of Alleged Abuse Preliminary Report form that abuse is substantiated.~~

~~f. Laguna Honda Human Resources Department shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine appropriate administrative course of action.~~

~~g. Laguna Honda Human Resources Department shall review all confirmed cases of resident abuse with the Deputy City Attorney. If a non-employee is identified as a suspect, the nursing supervisor or nurse manager shall contact the Sheriff's Department. The nursing supervisor or manager and the Sheriff's Department shall jointly carry out the investigation and initiate action to protect the resident.~~

~~h. The nurse manager or nursing supervisor will inform the resident of the findings of the investigation and will provide a feedback to the employee who reported abuse allegation.~~

ATTACHMENT:
Appendix One: Sample Guidance for "Conducting A Thorough Investigation"

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Suggestions and Complaints

LHHPP 76-04 Violence in the Workplace – Zero Tolerance
LHHPP B 3.0 Nursing Policy - Resident Funds
Form: "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement"
Form: Preliminary Investigation of Alleged Staff to Resident Abuse
Form: Preliminary Investigation of Resident to Staff Aggressive Behavior
Form: Preliminary Investigation of Resident to Resident Incident
Elder Justice Act of 2009

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12 (Year/Month/Day)
Original adoption: 05/20/92

APPENDIX ONE:

The following guidance represents the components of an investigation that would constitute a thorough investigation. Documentation of all aspects of the investigation is essential in order to provide evidence that all allegations were thoroughly investigated.

GUIDANCE TO CONDUCTING A THOROUGH INVESTIGATION

1. Identify the type of reportable incident (injury of unknown source or alleged abuse).

2. If abuse is alleged, identify the type of abuse (i.e. physical, verbal, sexual, mental, neglect, involuntary seclusion, misappropriation of resident property).

3. If the reportable incident is an injury of unknown source:

    a. Describe the injury.

    b. Document the size, location, color, pattern and number of injuries.

    c. What treatment was required and provided?

    d. Document if the resident has had similar injuries.

    e. Identify any diagnoses or medications that have the potential for placing the resident at risk for injury.

4. Consider and document the time of the last observation of the resident prior to the reportable incident. What was the resident's condition prior to the reportable incident? What was the resident's condition after the reportable incident?

5. If the reportable incident is a case of suspected abuse:

    a. Examine the resident for any signs of injury.

    b. Was there a change in the resident's "usual" demeanor?

    c. Accurately describe the first signs of injury or any change in the resident.

    d. Photograph any actual injury in a manner that will show a close-up view of the injury and will not include the resident's face or other identifying features. The staff taking the photographs should sign and date the photographs and document the name of the resident on the photograph.

6. Interview the person reporting the incident.

    a. Was the incident reported timely?

    b. What allegedly occurred?

    c. When and where did the alleged incident occur?

    d. If abuse is alleged, has an individual been identified as the abuser?

7. Develop a list of known and possible witnesses to the reportable incident.

8. Interview staff, residents, and/or visitors, or anyone who has or might have knowledge of the incident under investigation.

   a. Interview staff assigned to the resident at the time of the alleged incident.

   b. In addition, consider all possible witnesses such as housekeeping and dietary staff.

   c. Interview staff on other shifts that may have seen or heard something, such as 24 to 48 hours prior to the identification of the reportable incident.

   d. Attempt to narrow down the time of the alleged incident.

   e. Interview the resident in the same room, or residents in the immediate vicinity where the reportable incident occurred.

   f. Consider who may have seen or heard something and what they think could have happened.

   g. Observe and document any unusual demeanor of the person being interviewed

9. Identify the cognitive status of the victim(s) and resident(s) determined to be witnesses.

   a. Are they alert and oriented and able to answer questions appropriately?

   b. Can staff confirm the resident's ability to be an accurate reporter of the events?

   c. If so, document the interview with the staff related to the reliability of the resident.

   d. Review a copy of the resident's current MDS and the current plan of care, if applicable to the incident.

   e. If the witness (resident or roommate) is not alert and oriented, but the facility is utilizing the resident's statement in the investigation, explain why the resident is considered an accurate reporter (i.e., he/she has a history of consistently providing accurate information).

10. Review and have documentation of the alleged abuser(s) schedule for the 48-hour period prior to and the day of the reportable incident.

    a. When and where was the alleged abuser(s) working at the time of the incident? Be specific as to the hall, section, and room numbers. Review and compare the assignment and the witness statements for accuracy of pertinent dates, times, location, and persons present.

11. Review the alleged abuser(s) personnel record for a history of previous disciplinary actions, previous employment evaluations, background investigation, inservice record, and the status of the certification or license. Interview co-workers and/or residents to gain knowledge of their experiences with the alleged abuser(s).

12. Document any action(s) taken by the facility to protect the resident and to prevent possible retaliation during the investigation (maintain punch card reports to show alleged abuser(s) was suspended during the investigation).

13. Document any knowledge of bias between alleged abuser(s) and witnesses. What is the relationship between the witnesses and the alleged abuser(s) (i.e. professionals, friends, relatives, and enemies)? Is there a reason the witness would wrongfully accuse the alleged abuser?

14. Were agency personnel involved? Identify the name of the agency, the contact person, and the names, address, and phone number of the agency staff employee(s).

15. If the allegation involves alleged sexual abuse, did a nurse immediately examine the resident? Did the nurse document the findings? Document if a physician examined the resident and maintain a copy of the examination. Document specifically what immediate action was taken by the staff at the time of the alleged abuse, i.e., facility secured, notification of administrator, physician, responsible party, law enforcement, evidence secured (resident's clothing not removed, resident not bathed).

16. If the allegation involves neglect, attempt to identify the staff involved. How were they involved and what was the outcome to the resident? Maintain physical evidence related to the care of the resident in use on the day of the incident (i.e., written plan of care, communication tools used to direct care such as signs above the head of the bed, personal care records, CNA assignments sheets, facility communication sheets). Signed and dated copies of any forms or documents used in the care of the resident at the time of the incident. If applicable, review facility procedures if the incident may be related to unsafe technique. Review and maintain the manufacturer's recommendations related to the use of special equipment. Review and identify any nurse's notes or other facility records that may contain information relative to the incident. What interventions were in place prior to the reportable incident?

17. If the allegation involves misappropriation of resident property, clearly identify the missing items and their approximate value. Document the immediate action taken, i.e. notification of law enforcement, and responsible party. Obtain copies of bills, charge slips, vendor receipts.

18. Facility Investigative File: At the onset of the investigation, begin compiling the investigative file, to be maintained as a record. A complete investigative file may contain/but is not limited to the following:

    a. Reporting sheets completed by staff to internally report the incident (i.e. Incident or Unusual Occurrence Reports which are confidential reports under Section 1157 Code), as well as reporting documents such as the Preliminary Investigation forms as evidence of appropriate reporting to the State survey agency.

    b. Witness statements for all witnesses, alleged abuser(s), and resident if applicable. Include written statements not only from everyone involved in the incident but also everyone who participated in any way in the investigation.

c. Any written documentation related to an actual injury, (i.e., nurses notes, social work notes on the day of the incident and any other related dates), as well as pictures of the actual injury that identify the resident by name only, signed and dated by the staff member taking the photographs.

d. Related physician's orders, such as an order for a particular transfer device, or for x-rays if there is evidence or suspicion of injury.

e. The Resident Care Plan signed and dated by staff to show the care plan that was in place at the time of the incident.

f. Documents that serve as instruction to CNAs related to the care of the resident.

g. Manufacturer's recommendations related to the use of special equipment.

h. Inservice material with sign-rosters for equipment in use at the time of the injury that may potentially be involved in the cause of the injury (i.e., lift, transfer equipment, etc.). Include inservice and orientation records that show the staff was trained on any equipment related to the injury.

i. The schedule for all staff on the unit at the time of the injury and 24 to 48 hours prior to the injury.

j. Assignment sheets for staff caring for the resident at the time of the incident.

k. Documents that show action taken by the facility to protect the resident.

l. Name(s) of agency personnel on duty at the time of the incident, if applicable. Include the name of the agency, the contact person, and the names, addresses and phone numbers of all agency staff employee(s).

m. Documentation of disciplinary action of the alleged abuser(s) at the time of the incident and any other time during their employment with the facility. Include a copy of the background investigation prior to hire, and the current certification or license.

n. Documentation of any notification/referrals made as a result of the investigation such Board of Nursing or law enforcement.

SUMMARY REPORT OF FACILITY INVESTIGATION

Upon conclusion of the investigation, the facility should prepare a report to include details of the investigation, any actions taken by the facility (i.e., staff training, disciplinary actions, interventions to prevent further injury/alleged abuse), a summary of the findings and a conclusion of the investigation (i.e., was the allegation substantiated or unsubstantiated). Document any notifications/referrals made as a result of the investigation (i.e., law enforcement, Board of Nursing).

REFERENCE SOURCE:
http://www.scdhec.gov/health/cert/investigation.pdf#xml=http://www.scdhec.gov/cgi-bin/texis.exe/Webinator/search/xml.txt?query=conducting+a+thorough+investigation&pr=www&prox=page&rorder=750&rprox=750&rdfreq=250&rwfreq=500&rlead=1000&sufs=1&order=r&cq=&id=460c950b7

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

Dependent Adult/Elder Abuse Prohibition And Reporting Requirement

As an employee or volunteer of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda), you are either a health care practitioner or care custodian of dependent and elder adults and are expected to protect all Laguna Honda residents from abuse. If you see, are told of, or suspect abuse of a Laguna Honda resident, the law says you must report it. If you fail to report dependent adult or elder abuse or neglect, you may be guilty of a misdemeanor.

ABUSE INCLUDES:

Physical abuse:

- Assault (attempt to commit a violent injury)
- Battery (unlawful us of force or violence)
- Unreasonable physical constraint or prolonged or continual deprivation of food or water
- Sexual assault
- Use of a physical or chemical restraint or psychotropic medication for punishment or for a longer period or for a purpose other than that authorized by the physician providing medical care

Other abuse:

- Neglect
- Intimidation
- Cruel punishment
- Abuse of a resident's money, property or financial resources
- Abandonment
- Isolation

Where to report:

If you believe a report should be filed, contact your supervisor for assistance. An incident of abuse to any Laguna Honda resident must be reported to a long-term care Ombudsman. Instructions how to contact the Ombudsman are posted at the entrances to the Hospital and on every care unit bulletin board. In addition, an Unusual Occurrence form must be completed.

Contents of your report:

- Your name, address, telephone number and occupation
- The victim's name and address
- The incident date, time, and place
- Other details, including your observations and beliefs about the incident
- Any statement made by the victim
- Names of people believed to have knowledge of the incident
- Names of persons believed to be responsible for the incident; their connection to the victim

When to report:

You must report instances of abuse by telephone immediately, or as soon as possible, followed by a written report within two working days.

Exception:
When two or more persons have knowledge of the incident, one person may be mutually selected to make the report. However, if you know the person who was designated to report hasn't done so, you must make the report.

I have read the above statement and will comply with its provisions.

(Signature)	(Class Number & Title)
(Name - Print)	(Date)

Copy to Signatory

PHYSICAL RESTRAINTS INCLUDING SIDERAILS ~~AND MESH ENCLOSURE BEDS~~

POLICY~~IES~~:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) affirms the right of each resident to be free from any physical restraint imposed for purposes of discipline or staff convenience and not required to treat the resident's medical symptoms.

2. Restraints including physical confinement may only be prescribed to ensure the physical safety of the resident or the physical safety of other residents, with the overriding goal of enhancing the resident's ~~quality of life~~ safety and safety of others~~and optimal level of function~~.

3. Laguna Honda supports preventing, reducing and eliminating the use of restraints and restraint-associated risk through the use of preventive strategies, alternatives, and process improvements.

~~3. If a resident is admitted from acute using a mesh-enclosure bed, the treatment will be continued for 72 hours and will require further evaluation for a least restrictive restraint for safety measures.~~

PURPOSE:

To assure resident autonomy and freedom from physical restraints whenever possible, and to utilize restraints only when other less restrictive means to provide safety have been tried and determined to be ineffective.

DEFINITIONS:

1. Physical restraint: Any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

   A list of devices has not been given because each resident and his/her response to a device should be evaluated from a functional standpoint (i.e., a device that acts as a restraint for one individual may not inhibit the movement of another).

2. Siderails are considered restraints when:

   a. The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.

   b. The use of the siderail restricts freedom of movement.

STANDARDS / GUIDELINES FOR RESTRAINT USE:

1. A physical restraint can only be used if needed to improve the resident's well being and if less-restrictive interventions have been determined to be ineffective.

    a. Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff.

2. The use of a restraint must be:

    a. In accordance with the order of a physician or other person authorized to prescribe care, whose order must:

        i. Never be written as a on an as-needed basis (i.e., no PRN); and

        ii. Be followed by consultation with the resident's treating physician as soon as possible if the restraint is not ordered by the resident's treating physician;

    b. In accordance with a written modification to the resident's plan of care;

    c. Implemented in the least-restrictive manner possible;

    d. Applied in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident;

3. The condition of the restrained resident must be assessed, monitored, and reevaluated. Determination of the frequency of monitoring should be made on an individual basis, taking into consideration the individual resident's medical needs and health status.

    a. At a minimum, the following conditions should be monitored each shift:

        i. Physical and psychological status;

        ii. Readiness for discontinuation of a restraint;

        iii. Signs of injury associated with a restraint;

        iv. Circulation and condition of limbs;

        v. Skin condition, hydration, feeding, and/or toileting.

4. Only restraints approved by Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) are to be used. The appropriate size and type of restraint for the resident is to be applied following manufacturer's directions. Restraints are to be

applied so as to permit easy removal in emergency situations (e.g., in the event of a fire, disaster).

5. The use of a vest restraint in bed or chair shall not be employed.

6. If the RCT determines confinement is necessary to ensure the resident's well-being, and/or the well-being of other residents:

   a. This confinement must be voluntary and may only be implemented upon assessment of the following factors by the RCT members:

      i. What is the purpose of the stated restriction?

      ii. What specific behavior is being treated through the application of restriction?

      iii. What other less restrictive measures have been tried previously that have been unsuccessful in achieving the desired outcome?

      iv. Are there other less restrictive measures that could be tried again or that have not been previously tried, that could achieve the same or similar outcome?

      v. How will the effect of the restriction be evaluated?

      vi. Does the resident consent to the restriction?

   a.b. The RCT members must review the plan for confinement to ensure it is not involuntary except when it is a permitted or short term monitored separation from other residents for a limited period of time (suggest no greater than 24 hours) used as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs. Involuntary confinement that does not meet this provision must be immediately terminated.

PROCEDURES:

1. Procedure for Using Restraints:

   a. Before applying a new restraint:

      i. Consult with the Resident Care Team (RCT), consisting of at least the nurse and physician, to discuss and document:

         - Circumstances leading to the use of restraints and what less-restrictive interventions were tried first;

ii. The degree of effectiveness of the less-restrictive alternatives and how it was decided what type of restraint to use.

b. When a decision is made to order a new physical restraint:

i. Complete the Restraint Order Form (MR 154). If the restraint is a siderail, use the Siderail Order Form (MR 172) and refer to LHHPP 22-13, Siderail Use.

ii. Complete Consent for Physical Restraint forms (MR 812). Consents must include discussion with the resident, family, or surrogate decision-maker regarding:

- Reason for use of restraint (medical/behavioral).
- Type of restraint proposed and duration/frequency of use (cannot be PRN).
- Possible benefits and risks of using, or not using, restraints.
- Rights of resident or surrogate decision-makers to accept or refuse the use of restraints at any time.

iii. Update the resident's Care Plan:

- Include reason (medical/behavioral) for use of restraint.
- Describe specifically when the restraint will be used.
- Indicate the type of restraint being used.
- Document ongoing efforts to evaluate/eliminate use of the restraint.

iv. For a new order, the RCT will meet in a timely manner to discuss alternatives and plan for least-restrictive restraint(s).

c. For continued restraint use:

i. Ongoing use of restraints must be discussed with the RCT at least quarterly, although it can be discussed at an RCT "Special Review" at any time. Discussion should include:

ii. Resident's response to restraint being used.

iii. Possible alternatives/least-restrictive restraint to be used.

iv. Referrals to ancillary departments, as appropriate.

d. If the restraint is to be continued the order must be renewed on the Restraint Order Form (MR 154). This includes completing the section "Plan for Restraint Reduction" on the form.

2. Procedures for Using Restraints: Treatment

a. Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

3. Procedures for Using Restraints: Acute Patients (Medical or Rehabilitation)

a. Physician orders for the use of physical restraints in an acute care setting follow the same procedures as outlined above.

~~**4. Special Considerations for Use of the Mesh Enclosure Bed**~~

~~a. A Mesh Enclosure Bed may be considered for residents who are at high risk for falling out of bed and cannot be safely accommodated with a low-low bed.~~

~~i. Plant Services will perform a thorough inspection of each mesh bed before placing it in service. Nursing staff should check the bed daily for zipper integrity, entrapment hazards, and appropriate padding.~~

~~ii. Consent for restraints should be obtained per Medical Staff P&P C02-01 and this policy using Laguna Honda Form MR 812, Consent for Physical Restraints.~~

~~b. Ensure that adjustable-height beds using a high-low mechanism are not left in the up position when the patient is unattended; additional potential hazards for residents are created when the bed is left in the up position.~~

~~c. Mesh enclosure beds should not be used for residents exhibiting burrowing behavior; for residents who are violent, aggressive, combative, or suicidal; for residents who have multiple lines; or for residents with an excessive pica eating disorder.~~

~~d. Mesh beds should never be left unzipped when the resident is in the bed, unless the resident has 1:1 supervision.~~

~~e. The decision to discontinue use of a mesh enclosure bed should be determined by the physician in conjunction with other members of the Rehabilitation Team. Factors that may be considered at the time of discontinuing a mesh enclosure~~

~~bed may include, but are not limited to:~~

~~i. Improved mobility skills with increased safety of transfers.~~

~~ii. Improved safety awareness.~~

~~iii. Improved ability to follow commands or be redirected.~~

~~5.~~4. STAFF TRAINING

a. All staff who have direct patient contact must receive orientation training and subsequent annual education and training in the proper and safe use of restraints, including, but not limited to, the following:

   i. Methods to reduce and eliminate restraint use;

   ii. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger physical restraint use;

   iii. Use of non-physical intervention skills;

   iv. Choosing the least-restrictive intervention based on individualized assessment;

   v. Safe application of physical restraints;

   vi. Clinical identification of behavioral changes that indicate that restraint is no longer necessary; and

   vii. Monitoring physical and psychological well being of patients (e.g., respiratory and circulatory status, skin integrity, vital signs, etc.).

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-13 Falls
LHHPP 22-13 Siderail Use
Barclays California Code of Regulations: §72319. Nursing Service - Restraints and Postural Supports
State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 47, 06-05-09)

Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12 (Year/Month/Day)
Original adoption: 96/07/15

MANAGEMENT OF RESIDENT AGGRESSION

POLICY:

1. It is the policy of the San Francisco Department of Public Health to provide services in an environment that is safe and secure for all residents, employees and visitors. In order to achieve this environment, violence~~Violence~~ or threats of violence will~~are~~ not be tolerated from employees, residents, and visitors.

2. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) employees, volunteers and residents shall work to minimize the risk of aggressive/hostile events.

3. Laguna Honda shall establish a consistent and uniform response to such aggression or hostility should it occur.

4. Management of potential or actual aggressive or hostile situations occurring in a ~~the~~ neighborhood shall be the responsibility of the Resident Care Team (RCT) with the assistance of the San Francisco Sheriff's Department (SFSD) and the Department of Psychiatry staff as needed.

5. Management of potential or actual aggressive situations occurring in public spaces shall be the responsibility of the SFSD with assistance from the RCT.

PURPOSE:

To maximize the safety and security of residents, visitors, volunteers and employees.

PROCEDURE:

1. Staff Education

a. New employees will be provided with Safety Management and Response Techniques Training (SMART) during their orientation.

b. Clinical staff will be provided with annual SMART updates.

c. Annual SMART updates are also available for non-clinical staff members.

d. All staff will receive annual in-service on Prevention of Violence in the Workplace.

2. Assessment and Reports ~~of Residents~~

a. Pre-Admission Assessment

i. The Behavioral Assessment Team (BAT) will screen individuals with history of significant psychiatric and/or behavioral problems. (HWPP 20-01 Appendix B)

b. Nursing Assessments

i. See NPP G 6.0 ~~Nursing Staff will use the Nursing~~ Behavioral Risk Assessment and Guidelines for Care Planning.~~(MR340) to identify residents with behaviors that pose potential risk to themselves or others~~.

c. Resident Care Team (RCT) Assessments

i. The RCT assesses and monitors the resident's behaviors through:

- Daily observations
- Review of the Behavioral Monitoring Record (BMR) ~~(MR330 A & B)~~ to identify, track and review the potential risk behaviors
- Regular review and revision of the resident's plan of care
- Physician's Quarterly Psychotropic Review, which summarizes effects on behavioral symptoms targeted by psychotropic drugs
- Discussions during Resident Care Conference
- Unusual Occurrence (UO)
- Feedback from Department of Psychiatry staff as a part of their consultations to the RCT.

d. Behavioral Health Assessments

LHH Department of Psychiatry staff provide mental health, substance use and neuropsychological assessments, and assist the RCT in developing and implementing the resident's behavioral management plan.

3. ~~Early~~ Intervention

a. On Laguna Honda Neighborhoods/Units

i. In case of escalating aggressive behavior by a resident:

- The RCT is responsible for using SMART principles to attempt to safely to defuse potential or aggressive situations that occur on the unit.
- If needed, the RCT may request the assistance of the SFSD by dialing 4-2999, ~~asking the operator to page the Sheriff,~~ and giving their name, location, and the nature of the aggressive behavior event.

b. Outside of Laguna Honda Neighborhoods/Units

i. In case of potential or aggressive situations by a r~~R~~esident occurring in public areas:

- Employees, volunteers, or visitors in the area shall call 4-2999 and report the event~~ to the operator, who shall contact the SFSD~~.

- If an employee is present, he or she is responsible for using SMART principles if able to safely attempt to defuse the situation, while waiting for assistance from SFSD.

- The SFSD may request assistance from the RCT where the resident resides to further manage the disposition of the resident.

4. Management of Aggressive Behavioral Crisis ~~Without Intentional Risk of Harm~~

a. ~~In case of aggressive behavioral crisis without intentional risk of harm: ~~In case of aggressive resident behaviors involving weapons, or situations that pose risk of violence or injury, staff can call 4-2999~~ and report to the operator,~~ using the Dr. Grey" code.

b. The unit physician will assess ~~determine if the rResident's medical or psychiatric condition is ~~the likely cause of the aggressive behavior and intervene accordingly~~appropriately~~, including possible call to psychiatry urgent pager or after hour on call psychiatrist as needed.

~~If the rResident's aggression is likely caused by a psychiatric condition (including mental illness, traumatic brain illness, dementia and other neurological disorders), the unit physician will notify the on-call psychiatric staff, who will assess the resident and determine if the resident can be treated at a Skilled Nursing Facility level, or requires to be placed on a 5150 hold for further evaluation at Psychiatric Emergency Services (PES).~~

~~If the Resident's aggression is likely caused by a medical condition, the unit physician will assess and attempt appropriate medical interventions.~~

c. ~~If the Resident's aggressive behavior is likely caused by other factors (including environmental, relationship conflict or other external sources), ~~T~~t~~he RCT will assess for ~~to determine the cause(s) of the contributing non-medical and non-psychiatric causes (i.e., ~~environmental and/or psychosocial~~logical)~~ factors. ~~factors and implement reasonable efforts to resolve the contributing factor(s)/cause(s).~~

d. ~~The RCT will implement interventions~~ Initiate or revise the plan of care to safely care for the rResident and protect the staff~~, by creating or revising the plan of care (~~.~~including the Behavior Plan), including relocating the Resident to another room, household or neighborhood within Laguna Honda~~.

~~d.~~e. Any plan ~~that is created~~ must be communicated to all shifts to ensure consistency.

~~e.~~f. If staff requires assistance and wish to summon assistance from the SFSD without being detected, duress buttons are located under the desk in each nurse's station and in the living rooms at the end of the hallway of each household.

5~~In case of aggressive resident behaviors involving weapons, or situations that pose risk of violence or injury, staff can call 4-2999 and report to the operator~~Nursing office~~, using the "Dr. Greay" code~~.

~~**Management of Aggressive Behavior by a Resident With Intent to Cause Harm**~~

~~In case of aggressive resident behaviors involving weapons, or situations that pose risk of violence or injury, staff can call 4-999 and report to the operator, using the Dr. Grey" code.~~

~~If the SFSD officer establishes that a felony has occurred or witnesses a misdemeanor, the officer may arrest the rResident.~~

~~If the SFSD officer does not witness a misdemeanor offense, the officer may offer the victim the option of making a citizen's arrest.~~

Follow-up of Aggressive Incidents

a. If it is determined that the rResident who displayed aggressive behavior can continue to be safely cared for at Laguna Honda:

i. The RCT shall meet by the next business day to develop and/or update the ~~write a Behavior~~ Plan, of Care.

~~i.~~ The RCT shall ~~consider a~~ referral the resident for behavioral health consultation, if behavioral health consultants are not already involved.

ii.

~~This plan will describe the behavior goals of the rResident.~~

~~iii. If the rResident has adequate cognitive capacity, incentives for behavior change, as well as disincentives for non-adherence to the plan must be clearly communicated and understood by the resident, and~~

iii. A copy of the plan is provided to the rResident, if appropriate.

iv. The plan must be communicated to all shifts to ensure consistency.

b. If the resident is medically stable and can be safely discharged to the community:

i. The physician may discharge the resident.

i.ii. The Medical Social Services WorkrWorker, or designee, shall complete the Notice of Transfer/Discharge, explain the Notice and issue the Notice to the resident.

ii.iii. If a discharged resident refuses to leave the facility, the SFSD will be contacted.

6. Resident Witnesses or Vvictims of Aaggression

c. If a rResident witnesses or is a victim of aggression:

i. The resident will be examined by a physician and appropriate treatment initiated.

ii. Support and counseling will be provided by delegated members of the RCT.

iii. If indicated, a psychiatric consultation and follow-up will be ordered and provided to the rResident.

iv. The rResident will be observed until baseline behavior and mood indicate stability and goals are met as indicated in the plan of care.

7. Staff Witnesses or Victims of Aggression

i. The nurse manager or nursing director shall meet with involved staff to determine need for debriefing or defusing post-incident.

ii. If a Staff Incident Response Team (SIRT) meeting is deemed indicated, the nurse manager or nursing director will follow up with SIRT facilitators (members of Department of Psychiatry staff and Social Work Department).

7.8. Documentation

a. A Focused Progress note is entered into the rResident's medical record, including an objective description of the behavior, interventions attempted, outcomes, and follow-up measures taken.

b. ~~Complete and submit an~~ Unusual Occurrence (UO) ~~report~~

i. Following an aggressive incident, the staff witness of the event is expected to file a UO

~~The AOD report will be updated by appropriate staff as soon as possible for tracking purposes.~~

~~i.~~ ii. Log an ~~appropriate~~ entry in the Resident's Behavioral Monitoring Record.

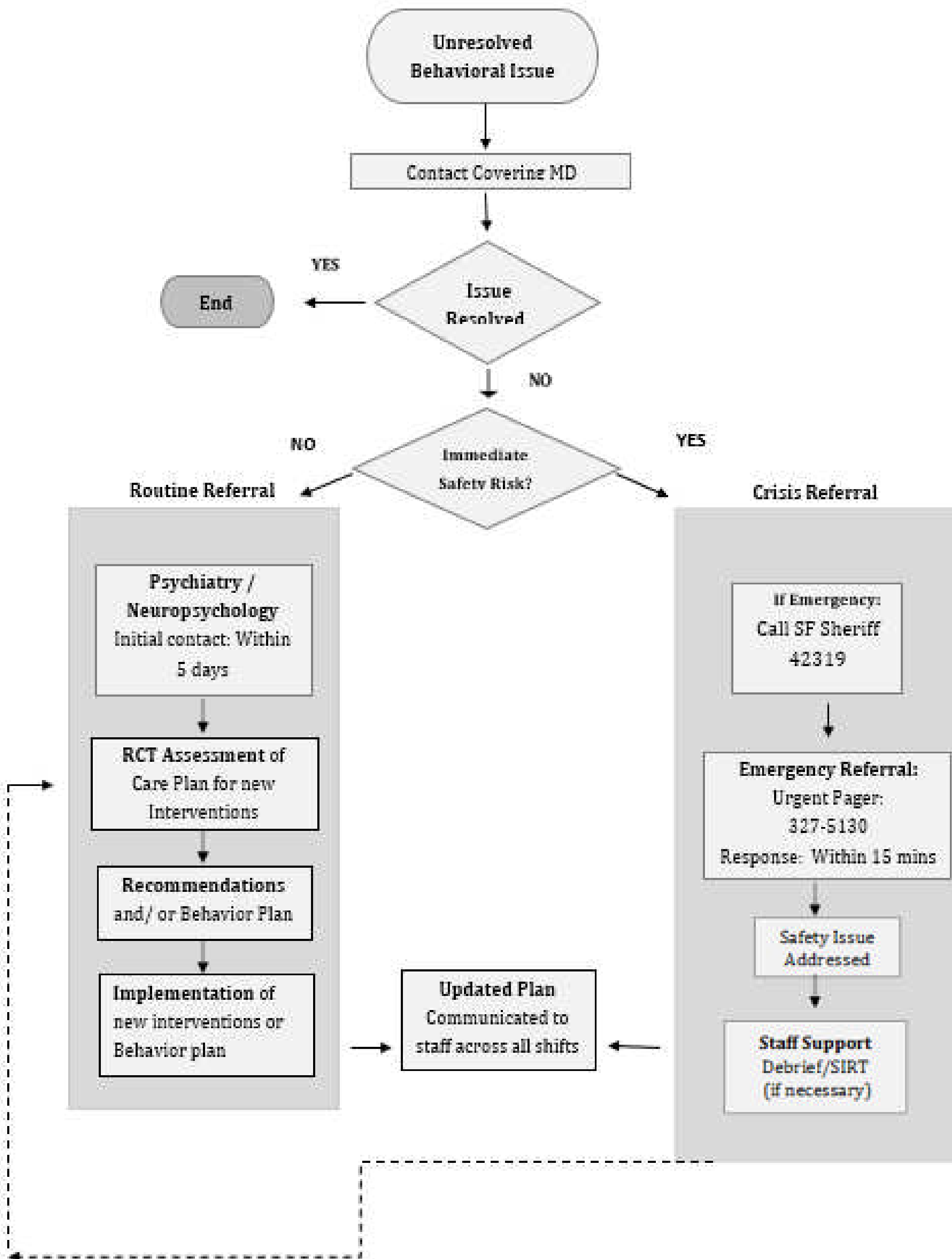
~~ii.~~ iii. Review and revise the Resident's care plan ~~, including the Behavioral Plan~~ as described under Section 6 ~~a (i)~~ above.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda & Relocation between SNF Units
LHHPP 20-04 Discharge Planning
LHHPP 23-01 Resident Care Plan, Resident Care Team and Resident Care Conference
LHHPP 60-04 Unusual Occurrences
LHHPP 75-04 STAT Calls For Sheriff's Assistance
LHHPP 75-06 Dr. Gre~~a~~y Code
LHHPP 76-04 Violence in the Workplace: Zero tolerance
Nursing Behavioral G6.O Risk Assessment & Guidelines for Care Planning P& P
Nursing P&PJ2.5 Monitoring Behavior & Effects of Psychoactive Medications
Physician P&P DO8-01 Acute Psychiatric Emergencies

Revised: 10/06/08, 16/01/12 (Year/Month/Day)
Original adoption:

Appendix 1:
Behavioral Health Process Flow Chart



RESIDENT COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) strives to create an environment that is promptly responsive to residents' complaints/grievances and addresses residents' concerns.

2. Laguna Honda encourages residents to raise ~~complaints or~~ concerns for immediate resolution with their care team (RCT), at community meetings, or at Residents Council without fear of reprisal.

3. When methods for resolving concerns ~~or complaints~~ have not been successful or resident chooses not to use any of the above methods, Laguna Honda has an additional formal mechanism for responding to significant complaints/grievances in a culturally sensitive manner.

PURPOSE~~S~~:

1. To ensure that significant ~~resident~~ complaints are addressed and appropriate follow-up actions are taken to resolve the ~~complaint~~ issueto the fullest extent possible.

~~2. To address systems problems to prevent recurrences of resident complaints.~~

~~3. To increase awareness of issues that are of concern for residents.~~

~~4.~~2. To ~~maximize~~ optimize the quality of life of the residents and ~~minimize dis~~satisfaction with the care and services in a timely~~, expedient~~ manner.

DEFINITION~~S~~:

~~Significant~~ Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints may include ~~expressed dissatisfaction of mealtimes, visiting hours or response time to call lights.~~those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives ~~a Resident Complaint Form in~~ the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy. ~~Signs informing residents and families of the process for making complaints and an example of the Resident Complaint form will be posted in each unit.~~

2. The Resident Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident's Rights annual in-services when policy changes occur.

3. Resident Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

   If the resident is unable to or does not wish to complete the complaint form, staff may document the resident's complaint/grievance on behalf of the resident. The Resident Complaint/Grievance form may be submitted to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to the Quality Management department.

   ~~using an Unusual Occurrence Form.~~

4. Quality Mangement staff will triage the complaint/grievance, create an Unusual Occurrence (UO) report, and follow up through the established UO process.

~~4. Administration staff shall check the drop boxes located at the 5th floor Nursing Office and at the main lobby weekly for complaints. Upon receipt of complaints, the Director of Administrative Operations will route the complaints to the appropriate manager or to the Resident Care Team (RCT) for review and follow-up. The Director of Administrative Operations will also provide a copy of the complaint to the Quality Management Coordinator for tracking purposes.~~

~~5. The appropriate manager, RCT and/or consultants will collaborate in the review process. This review may include interviewing the resident or the resident's surrogate decision-maker (SDM), and giving information about rights and options. The RCT shall assure the resident/SDM that the complaint will be reviewed within a specified time frame and shall provide the name of an easily accessible contact person.~~

~~6.~~5. The appropriate department head~~(s) shall supervise the overall review process and its documentation and respond in writing to the Quality Management Coordinator.~~ shall acknowledge the complaint/grievance and contact the resident in a timely manner (1 to 2 business days~~ (TBD)~~). If the complaint/grievance is anonymous, follow up with the complaintant is not possible.

~~7.~~ The resident's right to confidentiality and privacy will be respected at all times. ~~The RCT shall select a neutral party to interview any resident who expresses concern regarding staff neutrality.~~

~~8. At the time of the complaint, and again after a resolution is proposed, the resident/SDM must be informed by the Social Worker of the right to appeal to the~~

~~Office of the Ombudsman for review. *The Ombudsman must be called if the resident requires or wants representation or has no involved family or surrogate decision-maker.*~~

~~9. Next of kin or surrogate decision-maker shall be notified of the review and its outcome for residents who are conserved, who are unable to participate in the process for any reason, or for those who so request.~~

~~10.~~6. Laguna Honda staff may encourage a resident to complete the Resident Complaint/Grievance form when concerns are unresolved.

~~11.~~7. Resident complaints/grievances will be presented in aggregate at each ~~Hospital-wide Performance Improvement Committee (PIC)~~ Performance Improvement and Patient Safety (PIPS) meeting~~each month~~. Incidents will be evaluated and analyzed at the time with respect to follow-up, trends, problem identification and the prevention of future similar problem.

ATTACHMENT~~S~~:
Laguna Honda Hospital and Rehabilitation Center Resident Complaint/Grievance Form (to be revised)

REFERENCE~~S~~:
LHHPP 22-03 Residents' Rights
(add additional reference)
~~Department of Health and Human Services, Office for Civil Rights, Complaint of Discrimination form~~
~~Department of Health and Human Services, Health Standards and Quality Consumer Complaint Form~~

Revised: 09/10/01, 10/04/27, 16/01/12 (Year/Month/Day)
Original adoption: 92/03/01

~~LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER~~
~~RESIDENT COMPLAINT FORM~~

~~Note: Do not use this form for urgent problems. A nursing supervisor and a physician are available 24 hours daily and can be reached through the hospital operator.~~

~~Return this form to a resident drop box by the 5th floor nursing office, 1st floor lobby or ask any staff member to help you.~~

~~Name~~ ______________________________

☐ ~~if you wish to remain anonymous check this box~~

☐ ~~Resident~~

☐ ~~Family or Decision-maker~~ ~~Relation to resident~~ ____________

☐ ~~Other person~~ ~~Relation to resident~~ ____________

~~Date~~ __________ ~~Time~~ __________ ~~Your hospital location/unit~~ __________

~~How can we reach you?~~ ______________________________
~~If you wish to remain anonymous do not complete this line~~

~~Please be as specific as possible in your complaint. Include as much information as possible regarding times, dates, locations and names.~~

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~~For Internal Routing Purposes Only~~		
~~Route to:~~ ☐ ~~QM Coordinator date:~~	☐ ~~RCT date:~~	☐ ~~Dept. Head date:~~
~~CC to:~~ ☐ ~~QM Coordinator date:~~		

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER
375 LAGUNA HONDA BLVD
SAN FRANCISCO, CA 94116

RESIDENT COMPLAINT/GRIEVANCE FORM

TODAY'S DATE: TIME: PLEASE SEND COMPLETED FORM TO QM DEPTARTMENT

PART I. RESIDENT INFORMATION

RESIDENT NAME: ________________________________ DATE OF BIRTH: __________________ MR #:_______________ __
MEDICAL RECORD #

ADDRESS: ____
STREET CITY STATE ZIP CODE

TELEPHONE: ( ) _____________________ HEALTH PLAN: ☐ None ☐ Medi-Cal ☐ Other- _________________ ______

NAME OF YOUR USUAL DOCTOR/ NURSE PRACTITIONER & LOCATION: ____

PART II. CONCERN STATEMENT

DATE OF OCCURENCE: __________________________ TIME OF OCCURENCE: ___________________

LOCATION(S)/ DEPARTMENT(S) INVOLVED: ____

SUMMARY OF CONCERN (WHAT HAPPENED?). PLEASE INCLUDE NAMES AND/OR POSITION OF STAFF INVOLVED, IF KNOWN:

____
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PLEASE FILL OUT PARTS I, II, & III **USE AN ADDITIONAL SHEET IF NECESSARY**

PART III. CONCERN RESOLUTION

THANK YOU FOR TELLING US ABOUT YOUR CONCERN. PLEASE TELL US THE BEST WAY TO REACH YOU SHOULD WE NEED MORE INFORMATION: WRITE TO ME CALL ME I WILL CALL YOU

SIGNATURE OF PATIENT: ______________________________

NAME/ ADDRESS / PHONE # OF SPOUSE FAMILY MEMBER VISITOR WRITING CONCERN:

NAME	ADDRESS	CITY	ZIP CODE	PHONE

NAME/ TITLE/ PHONE # OF STAFF PERSON WRITING CONCERN:

FOR INTERNAL USE ONLY
PART 1V. CONCERN DISPOSITION

REVIEWED BY: TODAY'S DATE: CONCERN CODE(S):

DEPARTMENT(S) INVOLVED: STAFF INVOLVED:

SUMMARY:

PART V. RESOLUTION

DATE RESOLVED: LETTER OF RESOLUTION REVIEWED BY:

DATE COMMUNICATION OF RESOLUTION TO PATIENT/ FAMILY:

DATE OF RESOLUTION MEETING OR CALL:

SUMMARY OF RESOLUTION:

SUMMARY OF RESOLUTION (CONTINUED) ***NAME:***

MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

PROCEDURE:

1. Identification of At-risk Residents

a. Residents shall be evaluated by the Resident Care Team (RCT) and identified as being at risk for aspiration if they have clinical signs of swallowing difficulty/aspiration, demonstrate unsafe eating behaviors or have other conditions that place them at risk (e.g., reduced alertness, need to be fed in a reclined position, partially or completely edentulous with no dentures). At a minimum, the Resident Care Team includes a physician and a nurse.

b. If the resident is partially or completely edentulous with no dentures:

i. The RCT shall assess if the prescribed diet is deemed safe;

ii. The physician shall order a dysphagia evaluation if the resident's ability to safely swallow the prescribed diet is in question;

iii. The registered dietitian shall assess the resident's ability to tolerate the prescribed diet;

iv. The physician shall document discussion regarding aspiration risk if the resident is prescribed a diet other than pureed and;

v. The physician shall refer the resident to the dental clinic unless there is documented reason by the physician that the referral is not necessary.

c. Once a resident has been identified as being at risk for aspiration, Nursing will place a pink dot at the head of the resident's bed, give the resident a pink wristband, and affix a pink ribbon to the clothing of residents who leave the neighborhood unaccompanied by Nursing staff. Staff and volunteers shall be trained on this color coding system and what it means.

d. Residents who are assessed to be at risk for aspiration, (excluding those who are unable to eat by mouth (NPO), will be identified and have a physician's order for standard aspiration precautions, which include the following:

   i. Line of sight supervision when eating, unless documented otherwise in the Medical Record.

   ii. Resident shall be positioned as upright as possible when eating/drinking, and the resident's head prevented from tilting back, as possible.

   iii. Resident should be fed/cued to eat slowly, taking small bites.

   iv. When feeding a resident, make sure that the resident swallows each bite before continuing feeding.

   v. Resident should remain upright for 20 minutes after a meal.

2. Indications for Referral to Speech Pathology for a Dysphagia Evaluation

a. Residents who fall into one or more of the following categories shall be referred, by physician's order, to the Speech Pathology Department for a dysphagia evaluation:

   i. Those admitted with a known swallowing disorder, or history that is suspicious for dysphagia (unless NPO and not a candidate for oral feeding).

   ii. As described under Procedure 1 b (ii).

   iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: Coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.

   iv. Alert residents who are being considered for enteral feeding, unless clinically inappropriate (Refer to LHHPP 26-03, Enteral Tube Nutrition), and those on enteral feeding whose clinical condition has improved sufficiently that they may be candidates for oral feeding.

v. ResidentsPatients with a known swallowing disorder or clinical signs of dysphagia and/or aspiration who are being considered for a diet upgrade. (If a decision to upgrade a resident's diet has already been made for quality of life reasons, referral is not necessary, but may be indicated in order for a Speech-Language Pathologist to provide training regarding reducing the risk of aspiration on the upgraded diet. All necessary documentation regarding a resident's or surrogate decision maker's understanding of risks vs. benefits of upgrading diet and agreement to accept risks must be in place prior to the Speech Pathologist's intervention).

b. Referral to the Speech Pathology Department may also be indicated in cases of unexplained weight loss, dehydration, and/or poor oralp.o. intake, in order to rule out dysphagia as a contributing factor.

c. Dysphagia evaluation is by physician order only. The physician shall write an order and complete a consult request form. -If the evaluation is considered clinically urgent, the physician shall mark the consult "urgent" and call the Speech Pathology Department.

d. RCT members should alert the physician when signs of dysphagia, aspiration, or change in swallowing function are observed.

3. Dysphagia Evaluation

a. Dysphagia evaluations shall be carried out by a Rehabilitation CenterSpeech Pathologist per Speech Pathology Policyy and Procedure #930-053, Establishment of Treatment Programs and Documentation: Dysphagia.

b. Evaluation of Residents for Upgraded Food/Liquid Consistencies

When a dysphagia evaluation involves upgraded food or liquid consistencies not currently included in the resident's diet order, the following Tray Precautions will be taken:

i. The Speech Pathologist will contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket.

ii. The Speech Pathologist will notify Nursing and request that the tray not be served until the Speech Pathologist arrives.

iii. Nursing staff will hold the tray for Speech Pathology and will not give it to the resident.

iv. The Speech Pathologist is responsible for removing any food or liquid items not included in the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session.

4. Treatment

a. Following a dysphagia evaluation, the Speech Pathologist will proceed with swallowing therapy, when indicated.

b. If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, follow Tray Precautions delineated in paragraph 3b i-iv, above.

5. Referral to Occupational Therapy

a. Occupational Therapy consultation should be considered if positioning of the resident during feeding is difficult or body posture increases aspiration risk.

b. Occupational Therapy consultation requires a physician order and a referral form.~~.~~

6. Management of Residents Who are at Risk for Aspiration

a. Staff who are feeding or supervising residents designated to be at risk for aspiration are responsible for knowing and complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

b. Certified and Licensed nursing staff will be provided with mealtime competency training by Nursing Education or designated trainers upon hire and annually. Facility personnel will be trained on choking prevention and intervention upon hire and annually.

c. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and ~~on the left and right side entrance to each neighborhood.~~ designated areas.

d. Nursing is responsible for ensuring that family members and regular visitors~~-~~ who assist residents with their meals have been trained. If a family or volunteer needs additional training regarding feeding techniques, n~~N~~ursing may recommend referral to~~for~~ Speech Pathology~~ to train family members and/or other caregivers/staff, as needed~~. Staff ~~Speech therapy~~ will document~~ training of~~ family or volunteer~~/non-staff caregiver~~ training~~ shall be written~~ in the medical record and ~~included in the~~ resident care plan, including~~reflecting~~ the date of training.

~~e. Residents requiring thickened liquid will have "NEC" or "HON" (indicating liquid consistency of nectar or honey) written on a card and placed at the overbed namecard.~~

~~f.~~e. Residents with pink wristbands or pink ribbons should not be given or sold food/liquid by anyone who is not ~~familiar~~ aware of ~~with their individual needs and trained regarding aspiration precautions.~~ the residents' feeding needs.

~~g.~~f. Diet texture modifications (including thickened liquid) or enteral feeding, may be ordered to reduce the risk of aspiration. These interventions may be suggested by the Speech Pathologist following a swallowing evaluation but should be implemented only after careful resident assessment by the Resident Care Team (RCT) and orders changed by the physician. Diet texture modification for purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality of life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).

~~h.~~g. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP ~~E4.0, Nasogastric Tube Management and Medication, and E5.0, Gastrostomy and Jejunostomy Tube Management~~ E5.0 Enteral Tube Feeding Management).

7. Specialized Feeding Plans

a. A Specialized Feeding Plan (SFP) may be developed by the Speech Pathologist following a swallowing evaluation; the SFP includes more individualized precautions in addition to those stated above. Examples of SPF precautions include:

i. close supervision when eating and drinking
ii. provide cues/assist for unsafe eating behaviors
iii. thin down thick food
iv. small sips of liquid
v. alternate liquids and solids
vi. do not use straw
vii. cut food into small pieces
viii. cue resident to tuck chin
ix. cue or remind resident to swallow twice
x. cue to swallow food/liquid before taking the next bite/sip

b. The Speech Pathologist shall review the SFP with Nursing staff and provide training, as needed.

c. The Speech Pathologist will place the SFP in the Resident Care Plan (RCP) and notify the diet office regarding~~: re:~~ specific precautions to be printed on the resident's meal ticket.

~~c.~~d. The physician will include "Specialized Feeding Plan" as part of the diet order. Nursing will include this information when communicating the diet order to Nutrition Services.

~~d.~~e. For residents with SFPs, Nutrition Services will print "SFP" and the list of special precautions on the meal ticket, providing an easy reference for caretakers.

~~e.~~f. Residents with SFPs whose swallow function appears to have improved or declined should be referred to Speech Pathology for re-evaluation and updating of the SFP, as needed. When a reevaluation is not indicated and Speech Pathology is no longer treating or routinely re-checking the resident, the Speech Pathologist will be invited to attend RCT meetings for residents who have SFPs.

8. Follow-Up

a. The Speech Pathology Department is available to monitor any resident during a meal who has been seen for a dysphagia evaluation, is on the diet recommended by Speech Pathology, and has not had any change in condition. The request may be made by any member of the RCT. No physician's order is required. The Department should be contacted directly by phone. A physician's order for a re-evaluation is required for patients whose diet was either upgraded or downgraded without the involvement of the Speech Pathology Department, when there has been a change in condition, or when re-evaluation for diet upgrade is being requested.

b. When an order for an SFP is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician and licensed nurse. ~~and Nursing~~ The Speech Pathology Department shall be informed that the ~~(call or fax) the Speech Pathology Department that the~~ SFP has been discontinued. Diet office should also be notified in order to delete the info from the tray ticket~~When an order for an SFP is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician~~. ~~and licensed nurse, and Nursing shall inform (call of fax) the Speech Pathology Department that the SFP has been discontinued.~~

9. Documentation on Informed Decision

a. When the resident or surrogate decision maker chooses to accept the risks of a diet upgrade, or not to accept the recommendation/benefits of a therapeutic diet and feeding interventions; documentation of discussion regarding informed

decision shall be reflected in the Resident Care Conference meeting notes, advance directives and the resident care plan.

b. The resident care plan shall include care plan approaches for minimizing the risk of aspiration.

10. Others

a. Regardless of the code status, residents will be provided with rescue interventions in the case of choking or aspiration events

b. The Medical Examiner will be contacted by the physician in the case of choking or an aspiration event that leads to death.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Close Observation
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
~~NPP E4.0 Nasogastric Tube Management and Medication~~
~~NPP E5.0 Gastrostomy and Jejunostomy Tube Management~~
~~Speech Pathology~~Rehabilitation Center P&P 90~~30~~-05~~3~~ Establishment of Treatment Programs and Documentation: Dysphagia.

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12 (Year/Month/Day)
Original adoption: 98/04/01

WIRELESS ~~REFRIGERATOR AND FREEZER~~REFRIGERATION AND WARMING TEMPERATURE MONITORING SYSTEM

POLICY:

1. **All blanket warmers, medication, nutrition and specimen related refrigerators or freezers will be part of the wireless temperature monitoring system.**

   a. Any new refrigerator, freezer or blanket warmer put into service, will have the wireless temperature sensor installed when the refrigerator is delivered.

   b. Any refrigerator or freezer that is replaced will need to have maintenance remove the wireless temperature sensor from the old appliance and installed into the new appliance.

   c. If a medication refrigerator or freezer is sent to maintenance for repair, the manager or designee of the area will assure that all medications are moved to a medication refrigerator or freezer that is monitored by the wireless temperature monitoring system.

   d. The manager or designee will need to assure that the temperature is within defined limits before placing medications into the refrigerator or freezer.

2. **All refrigerators and freezers will have designated alarm settings.**

   a. Medication refrigerator (36 – 46 degrees F), freezer (< 5 degrees F)

   b. Nutrition refrigerator (33 – 41 degrees F), freezer (minus 30 – 0 degrees F)

   c. Specimen refrigerator (36 – 46 degrees F), freezer (minus 30 – 14 degrees F)

   d. Blanket warmer (no lower limit – 135 degrees F) normal operating temperature set no higher than 130 degrees F

3. **All refrigerators, freezers and blanket warmers will have alarms routed to a designated individual for responses to alarms. This will be by pager with an e-mail/page going to the designated staff person.**

   a. Departments are responsible to assign the wireless refrigerator, freezer, and blanket warmer temperature monitoring system pager alarms to designated individuals.

   b. Each department is responsible for notifying Facility Services of changes in the wireless refrigerator, freezer temperature, or blanket warmer monitoring system access list.

c. For Departments that do not operate 24/7, the wireless refrigerator, freezer or blanket warmer temperature monitoring system pager alarms will be automatically routed to nursing operations after hours.

PURPOSE:

1. To automate (using radio frequency) refrigerator, freezer, and blanket warmer temperature monitoring and recording.

2. To notify staff via pager of temperature out of range that need corrective action to assure appropriate storage of refrigerated items and meet regulatory requirements.

PROCEDURE:

1. Calibration of System

a. Facilities will calibrate the system on a yearly basis.

2. Documentation for Temperature Monitoring

a. The designated department will check the refrigerator/freezer sensor readings twice a day. The check will be documented as initials on a temperature monitoring log maintained in the department. The first check each morning will include a review of the "Daily Sensor Report/ 12Hr" report for the previous 24 hours or longer if the department is not open 7 days/week.

Department Responsibility

i. Pharmacy all medication storage refrigerators/freezers
ii. Nutrition services all nourishment refrigerators/freezers
iii. Lab all specimen storage refrigerators/freezers
iv. Nursing will document twice daily the status of refrigerators, freezers, and blanket warmers. The response to alarms for refrigerators and freezers is described in Section 3 and the alarm response for blanket warmers is described in Section 4. Performing off-hour procedures is described in Section 5. .

b. At the beginning of each month, the designated department will print a "TempTrak Equipment QA / Performance Report" for the preceding month and file with the temperature log**.**

3. Alarm Responses (Refrigerators or Freezers)

a. When a designated individual receives a "refrigerator or freezer out of range alarm" it will be indicative of the temperature being out of range for 120 minutes and must be responded to within 30 minutes.

b. After 30 minutes of no response to the alarm, the initial alarm will be resent.

c. After 45 minutes of no response to the alarm, the escalation notifications in place will be activated.

d. The responsible individual will go to the identified refrigerator or freezer and problem-solve the reason for an out of range alarm (i.e. door open, thermostat needs adjustment, motor broken). The actions taken (e.g. to shut the door, reset the thermostat to the correct setting, call facilities) will be documented in the "Corrective Action/Notes" section of the alarm response.

   i. If the refrigerator/freezer does not return to the designated range notify Facility Services and document this action in the "Corrective Action/Notes" section of the alarm response.

e. If a refrigerator or freezer used for medication storage is out of range, the Pharmacy should be contacted to assist with determining if drug stability has been affected by temperature changes during the out-of-range length of time. Drugs whose stability may have been affected by a temperature change should be segregated and placed into a refrigerator or freezer with the proper storage temperature until it is known whether the drugs are still suitable for patient use.

   i. Document the notification of Pharmacy to assess drug stability in the "Corrective Action/Notes" section of wireless refrigerator and freezer temperature monitoring system.

4. Alarm Responses (Blanket Warmer)

a. When the charge nurse receives an alert via page indicating "blanket warmer out of range", the charge nurse will respond by checking the blanket warmer for possible causes and adjusting the temperature when needed. Document action on Temp Trak.

b. After 30 minutes of no response to the alarm, the initial alarm will be resent to the charge nurse and nursing operations.

c. To eliminate the alarm sounding off the equipment open the door, turn the thermostat dial down to 130 degrees F and wait for the thermostat to read 130 degrees F. Then, close the door.

5. Off-Hours

For areas that do not operate 24/7, alarms will be responded to by the watch engineer and nursing operations.

a. For Departments not operating 24/7, the staff will review temperature logs as part of their opening procedures. Nursing operations will notify department of off hour alarms.

b. Alarms for refrigerators or freezers located inside the pharmacy during off hours, nursing operations will contact the on-call pharmacist to assess the alarm.

REFERENCE:
NPP D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerator via TempTrak & Cleanliness of Refrigerators
NPP D9 9.0 Appendix 2 – Refrigerator TempTrak Brief Reference Guide
NPP M 11.0 Warmer Protocol

REFERENCE:
None.

Revised: 14/11/25, 16/01/12 (Year/Month/Day)
Original adoption: 11/11/29

APPENDIX A:

Temp Trak Pager List

Location	First Page Number	Unit Med and Nourishment Refrigerators	Escalation M-F 0800-1700 After 30 minutes if no response	Escalation on Nights/Weekends/Holiday
PM pager	**415-327-8713**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
South 6 pager	**415-327-8712**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
South 5 pager	**415-327-8711**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
South 4 pager	**415-327-8710**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
South 3 pager	**415-327-8709**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
South 2 pager	**415-327-8708**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 6 pager	**415-327-8707**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 5 pager	**415-327-8706**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 4 pager	**415-327-8705**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 3 pager	**415-327-8704**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 2 pager	**415-327-8703**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
North 1 pager	**415-327-8702**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
NM pager	**415-327-8701**	x	(415) 327-8019 Nurse Manager	(415) 327-8023 Nursing Ops
Pharmacy TempTrak Pager	(415)327-1150	All Med Storage Refrigerators/Freezers		(415) 327-8023 Nursing Ops (Call on call RPh) and Facilities
Clinic	(415)327-0333	Clinic Refrigerators		(415) 327-8023 Nursing Ops and Facilities
Lab	(415)327-4904	All Specimen Refrigerators		(415) 327-8023 Nursing Ops and Facilities
Dietary	(415) 327-1184; (415) 327-1181; (415) 327-1125	All Nourishment Refrigerators/Freezers in kitchens		(415) 327-8023 Nursing Ops and Facilities
Facilities	(415) 327-7755	All Refrigerators		Facilities
Nursing Ops	(415) 327-8023	All Refrigerators after hours		Facilities

HOSPITAL EQUIPMENT AND SUPPLIES BUDGET AND PROCUREMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall have available equipment and supplies needed to render appropriate care to residents.

PURPOSE:

To ensure that physician-ordered care can be provided at all times through the use of equipment and supplies.

PROCEDURE:

1. The Finance Manager or a Designee

a. Shall establish budgeting, appropriation management, purchasing and expenditure accounting policies and procedures.

2. The Associate Administrator for Operations

a. Shall establish Materials Management and Central Supply~~commissary~~ inventory control policies and procedures.

3. Division Heads

a. Shall be responsible during budget preparation to make adequate annual appropriation requests for suitable equipment and supplies for their divisions.

b. Shall be responsible to expend appropriated funds to ensure that priority is given to equipment and supplies necessary to maintain essential services.

4. Department Heads

a. Shall be responsible during budget preparation process to make adequate annual appropriation requests for suitable equipment and supplies for their departments and otherwise make every effort to enumerate all equipment and supplies deemed necessary to maintain a legally compliant and high standard of resident care;

b. Shall be responsible to expend appropriate funds in a timely fashion to ensure that priority is given to equipment and supplies necessary to provide ordered or indicated services; and

c. Shall be responsible to implement within their departments equipment life-cycle projections, inventory controls, and par estimates sufficient to assure that equipment and supply orders are placed in a timely fashion which take into account known order requirements, bid specifications, constraints, and order lag time of the City Purchaser.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 02/01/02, 92/05/20, 07/12/18, 11/05/13, 15/03/10, 16/01/12 (Year/Month/Day)
Original adoption: 88/01/22

RESIDENT TRUST FUND

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) to enable and encourage residents to manage their personal funds, and, upon written authorization of the resident, for Laguna Honda to hold, safeguard, manage, and account for the resident's personal funds that are deposited with Laguna Honda.

PURPOSE:

To provide guidance to safeguard resident's monies and valuables within Laguna Honda, to maintain an accurate record of residents' deposits and expenditures, to assist residents in handling their funds, and to maintain Laguna Honda's fiscal responsibility.

DEFINITION~~ of PROGRAMS~~:

1. Medi-Cal current rate: A dollar amount per month that qualified residents may draw. Medi-Cal periodically changes this current rate, which is available from the Laguna Honda ~~Cashier.~~Admissions & Eligibility (A&E) financial counselor.

2. SSI Current Rate: A dollar amount per month that qualified residents may draw. SSI periodically changes this current rate, which is available from the Laguna Honda ~~Cashier~~A&E financial counselor.

3. **Representative Payee Program, Legal Conservator and Public Guardian**

   a. In most situations, a resident is presumed to be capable of managing their funds. Residents may have a Public Guardian or other legal conservator appointed to manage the residents' money. As an alternate option, the resident or legal conservator may elect to have Laguna Honda as the representative payee. The main responsibility is to ensure that money spent is to pay for the needs of the resident and properly save any money not needed to meet current needs. Laguna Honda as representative payee must also keep records of expenses. To become the representative payee, Laguna Honda must submit forms SAA-787 and SSA-11 (completed by A&E financial counselor.

   b. **Regulations Defined by the Medi-Cal Program**

      i. Personal Needs Allowance:

      ii. Residents who are Medi-Cal eligible may receive up to the Medi-Cal current rate for personal use.

      iii. Residents on SSI may receive up to the SSI current rate for personal use.

c. Medi-Cal/SSI Asset Limit and Share of Cost:

i. For Medi-Cal recipients, the responsible A&E financial counselor contacts the resident or other responsible person to initiate spend-down of their trust fund. Refer to A&E policy number 05-02, Notification of Excess Personal Assets.

ii. Recipients in the SSI program do not have a share of cost. When admitted to LTC a person's SSI benefits are decreased to $50.00 for their personal needs. Asset must remain below $2000.00

iii. The New Medi-Cal Eligible ACA Program does not have an asset limit or SOC and does not require residents to Spend-down.

iv. Traditional Medi-Cal, which includes aged and disabled persons, still requires eligible persons to have assets below $2,000 to remain eligible for the Medi-Cal Program.

d. Burial Account:

i. Money that is not subject to the resident's resource limit amount.

ii. Resident may reserve amounts in a prepaid burial trust (or as otherwise allowed by law) money that is not subject to the resident's resource limit amount.

PROCEDURE:

1. **Establishing Resident Trust Account:** At the time of the resident's admission to Laguna Honda, the Admissions & Eligibility (A&E) financial counselor assists the resident in establishing a patient trust account at Laguna Honda. The A&E financial counselor will encourage the resident to arrange for direct deposit of his/her funds into a resident trust account. The Accounting Department may consolidate into a single trust two or more trust accounts of a given resident; however, the resident's trust account shall not be co-mingled with facility funds or with the funds of any other person.

2. **Accounting of Resident Trust Account:** The Accounting Department issues a fiscal quarterly "Resident Trust Fund Statement" (hereafter Statement) ending September, December, March and June. The Statement is delivered thru interdepartmental mail to individual Nursing Neighborhood and the nurse manager or designee of each Nursing Neighborhood will distribute the Statement to residents. When a legal representative has been designated to manage the residents' funds, Accounting Department delivers the Statement to the A&E Department who then in turn distributes by mail to the residents' legal representative. Upon the death of a resident, the A&E Department will convey within 30 days the resident's funds and a final accounting of those funds to the individual for probate jurisdiction administering the resident's estate. It is the responsibility of the A&E financial counselor to withhold any payment from SSI and SSA after the resident expired by requesting the Accounting to transfer the fund to SS-Rsv for future 'Take Back' from SSI/SSA.

3. Nursing Neighborhood Money Held by the Nurse Manager or Designee

a. Money held by the nurse manager or designee is secured in the Nursing safe with restricted access. The nurse manager or designee is not to hold more than $50 for the resident. However, for a certain period of time, but not more than 30 days, the nurse manager or designee may have more than $50 for the resident when private funds belonging to the resident have been entrusted to the nurse manager or designee and have not yet been deposited into the residents' trust account.

b. Residents who have financial decision-making capacity must sign a transaction record when money is received.

c. At the time of the resident's death, the nurse manager promptly shall deposit all of the resident's funds into the residents' trust account.

4. **Resident Has Financial Decision Making Capacity and Requests Withdrawal of Money from the Patient Accounts/Cashier Window:** If the resident wishes to withdraw funds from his/her patient trust account, the resident completes the "Authorization to Accounting Office form (ATAO). The form must be signed by the resident or resident's representative and countersigned by A&E Supervisor and/or A&E Manager, or designee.

   The A&E Supervisor must sign requests for check. Authorizations over $300 must be counter-signed by A&E Supervisor and A&E Manager, or designee. The Director of Patient Financial Services (PFS) or designee must sign authorizations over $1000.00 without the resident's signature. Authorizations over $300 must be counter-signed by A&E Supervisor and A&E Manager, or designee.

   A&E PFS Director's signature is not required for authorization amounts up to $1500.00 if the resident signs authorization. Cash will be authorized if resident is being final discharged from Laguna Honda. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.

5. **Annual Authorization to Withdraw Monthly Allowance:** Annual Authorizations (A&E and Cashier). The resident may choose to receive his/her monthly allowance (Medi-Cal current rate or SSI current rate) through Annual Authorization by completing and signing the ATAO form. The A&E financial counselor writes on the top of the form "Annual Authorization", and an expiration date. The A&E financial counselor forwards the original copy to the Cashier. A copy of the form is filed in A&E file. The Cashier will file the ATAO original copy to use as reference to verify residents who participate in Annual Authorizations. Annual authorization covers monthly allowance not to exceed $50.00. Amounts over the $50.00 limit or additional requests for withdrawal requires resident to sign an ATAO form for each request. Annual Authorizations are renewed on December 31st of each year. Residents wishing to continue with annual authorizations must complete a new authorization for

the upcoming year. The annual authorization form is used only for residents with decision-making capacity and are able to handle their own funds. All other requesting funds must use the regular ATAO form.

6. Steps for Authorization of Funds:

   a. The expenditure of the funds is intended for the resident's use to provide for his/her comfort and happiness. Included in the legitimate use of resident's funds, but not limited to these are:

      i. the purchase of specially prepared or alternative food that meets the resident's dietary needs instead of the food generally prepared by Laguna Honda;
      ii. telephone; clothing; personal comfort items, including novelties, and confections; cosmetics and grooming items in excess of those for which payment is under Medi-Cal or Medicare;
      iii. reading materials; social events and entertainment offered outside the scope of the activities program;
      iv. flowers and plants; and television/radio/audio appliances for personal use

The following chart displays required signatures for authorization or withdrawal from the resident's account:

Withdrawal Amount	Amounts up to $50.00	Additional signature if exceeds $50.00	Additional signature if amount exceeds $300.00	Additional signature if amount exceeds $1,000.00 w/o Residents signature or $1500.00 with residents signature
Signature Requirements	Resident or Medical Social Worker and A&E Financial Counselor	A&E Supervisor or designee	A&E Manager or designee	Director of PFS, CFO, or designee

7. The Laguna Honda A&E Manager may approve authorization for any amount when funds are intended for burial, pending discharge, distribution of funds for a deceased resident or funds authorized to Department of Human Services, Public Guardian, Public Administrator, or a legal conservator.

8. Medi-Cal Spend down:

a. LHH is the decision maker: A&E sends an email notification to the social worker and nurse manager when the residents account reaches $1500.00. A second notification after 30 days. The final email notification is sent 30 days later or when the account reaches $1900. (See attachment A for notification letters.)

b. Resident/Family or Conservator is the decision maker: A&E financial counselor will contact the family to spend down

9. Authorizations Requested by Resident

a. Residents who are capable of managing their own funds will complete the authorization form for withdrawal of funds:

  i. The A&E financial counselor reviews trust account ledger to verify that funds are available.

  ii. If authorization is a final liquidation of the resident account due to discharge or death, ADL (1) screen of resident's account will be printed and attached to ATAO.

  iii. The A&E financial counselor completes the ATAO and has the resident sign the form to authorize withdrawal of funds.

b. If amount of the request exceeds $50.00, the A&E Supervisor's signature is required on the authorization form. (Refer to authorization chart above).

c. A&E financial counselor will authorize if requested funds are for the benefit of the resident.

d. Any amount over $300 will be issued by check. Cash will be authorized if resident is final discharged from Laguna Honda.

e. For cash requests, the white copy of the authorization is given to the authorized decision maker to take to Cashier to get his/her funds; yellow copy is placed in A&E supervisor's mailbox for auditing purposes; pink copy is placed in resident's chart along with copies of identification and receipt(s) or invoice to A&E copy of ATAO.

f. For check requests, the A&E financial counselor sends the white copy and yellow copy of the ATAO form to Cashier and files pink copy in residents' file.

g. When A&E financial counselor receives the check and yellow copy of the ATAO, check is delivered/mailed, yellow copy replaces pink copy in resident file and pink copy is forwarded to A&E supervisor.

h. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.

10. Reimbursement to Authorized Decision Maker when Resident Lacks Financial Decision Making Capacity

11. If a resident lacks capacity to make financial decisions, person identified by the Medical Social Worker (MSW) as the person having authority to access that resident's Trust Account. Persons who are not the authorized decision maker will be referred to the MSW.

a. Steps for Establishing and Authorizing Funds to the Authorized Decision Maker:

i. MSW will provide A&E with name and contact information of person authorized to access the resident's trust account.

ii. A&E financial counselor will enter authorized decision makers name and contact information into Invision Clinical Management System.

iii. The A&E financial counselor will verify that person requesting funds is the authorized decision maker. If not, the person will be referred to contact the resident's social worker.

iv. If the person is authorized to access funds, the A&E finance counselor will review the trust account ledger to verify that funds are available and ask the person to provide Government identification.

v. The authorized decision maker must submit a written request for funds indicating amount and reason for the request.

vi. Receipts for resident purchases must be submitted for reimbursement by authorized decision makers when the resident lacks financial decision making capacity.

vii. Refer to item 8a thru 8k for steps on authorization of funds.

12. Authorization Request by MSW

a. If in the opinion of the residents' care team, the resident is unable to manage his/her funds and the resident does not have a legal representative, the hospital or designee will designate the MSW to manage the resident's funds. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.

b. Steps for Authorizing Funds to the Medical Social Worker:

i. The MSW will notify the A&E financial counselor of request for funds in writing indicating amount and reason for the request.

ii. The MSW will submit receipts for purchases to the A&E financial counselor within one week.

iii. The MSW will maintain a transaction record, which must be signed by the resident whenever money is distributed to the resident. The transaction record will be forwarded to the A&E financial counselor, who will place the form in the resident's file.

iv. Refer to item 8a thru 8k for steps on authorization of funds.

c. Monitoring Compliance: The A&E supervisor will conduct a random sample audit each month, reviewing and reconciling receipts against funds withdrawn and reimbursed to the authorized decision maker. The A&E Manager is responsible for monitoring compliance.

ATTACHEMENT:
None.

REFERENCE:
Nursing Department Policy for Handling Money Held on the Nursing Neighborhood

Revised: 98/11/16, 00/05/25, 04/12/02, 07/12/18, 10/04/27, 10/08/10, 11/03/24, 16/01/12 (Year, Month, Day)
Original adoption: 93/09/01

LAGUNA HONDA RESIDENT NOTIFICATION OF EXCESS PERSONAL ASSETS

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) Admissions and Eligibility (A&E) Department, to ensure that residents residing at Laguna Honda adhere to the Medi-Cal Program regulation regarding personal property limits.

Laguna Honda A&E financial counselors are responsible for understanding the Medi-Cal Regulations and rules regarding excess assets and spend-down. They also have responsibility for ensuring that an application is completed and submitted to the Medi-Cal Program once residents' assets are within Medi-Cal limits.

Regulations Defined by the Medi-Cal Program:

1. Medi-Cal/SSI Asset Limit and Share of Cost:

   a. For Medi-Cal recipients, the responsible A&E financial counselor contacts the resident or other responsible person to initiate spend-down of their trust fund. Refer to A&E policy number 05-02, Notification of Excess Personal Assets.
   b. Recipients in the SSI program do not have a share of cost. When admitted to LTC a person's SSI benefits are decreased to $50.00 for their personal needs. Asset must remain below $2000.00
   ~~a.~~c. The New Medi-Cal Eligible ACA Program does not have an asset limit or SOC and does not require residents to Spend-down.
   ~~b.~~d. Traditional Medi-Cal, which includes aged and disabled persons, still requires eligible persons to have assets below $2,000 to remain eligible for the Medi-Cal Program.

PROCEDURE:

1. **Prior to admission, the Laguna Honda Hospital and Rehabilitation Center admission coordinator or designee will inform residents requesting admission to Laguna Honda, or their representative of payment requirements described below in sections a-c.**

   A&E financial counselors are responsible for informing current residents, or their representatives of Medi-Cal requirements, including updates on Medi-Cal Regulations for property limit and spend-down of excess assets.

   a. Medical Spend Down of a Medi-Cal Applicant

      i. A&E financial counselor informs persons requesting admission to Laguna

Honda with assets exceeding the Medi-Cal Property limits of Laguna Honda's deposit and payment policies. Residents, their families or legal representatives are provided with the Laguna Honda payment agreement. A signature confirming that the document has been reviewed and understood must be submitted to the Laguna Honda admission coordinator before admission to Laguna Honda. In addition, a minimum deposit is required based on the type of service and estimated days of admission to Laguna Honda as described further below.

b. Medical Acute Admission

i. Requires a minimum deposit equal to the estimated length of acute stay, up to a 45 day stay, or until the resident's assets are within the Medi-Cal asset limit.

c. Acute Rehabilitation Admission

i. Requires a minimum deposit equal to estimated length of stay, up to a six-week stay, whichever is shorter.

d. SNF Admission - A minimum deposit up to three months stay, or until the resident's assets are within the Medi-Cal asset limit.

2. **A&E financial counselors will use the following Medi-Cal regulations to base determination of excess assets:** Medi-Cal Eligibility Manual Procedures Section No: 50421 Manual Letter No.: 131 (Excess Assets Applied to Residents Bills)

a. A Beneficiary (resident) remains responsible for medical expenses incurred by him/her when:

i. The applicant (resident) has medical bills in a month for which retroactive coverage is being requested and property was reduced to pay those bills before the end of that retroactive month.

ii. When excess property was reduced during the month to pay for medical expenses.

iii. When a period of ineligibility due to a transfer of property occurring before January 1, 1990, expires mid-month and actual medical expenses in that month were used to reduce the period of ineligibility.

iv. The actual medical expenses used to reduce the period of ineligibility is not refunded to the beneficiary or billed to Medi-Cal. All other medical services not paid by the beneficiary may be billed to Medi-Cal.

v. NOTE: Under the share of cost process, where a beneficiary's excess income

must be applied towards his/her medical care. The same medical expenses cannot be used to meet an applicant or beneficiary's share of cost.

b. Non-Exempt Assets:

i. Non-exempt assets, which may include inheritances, gifts, sale of real property or a revocable trust fund may cause a loss of benefits to an otherwise Medi-Cal eligible person. Residents who are discontinued from the Medi-Cal Program due to excess assets are responsible for payment of all charges associated with their admission. (Refer to section 1a -d). Non-exempt lump sum payments from the following are included in the property reserve effective the month of receipt:

- Annuities
- Veteran's Payments
- Pensions
- Railroad Retirement
- Unemployment Benefits
- Non-SSA Disability payments
- Non-SSA Retirement payments

c. Exempt Assets:

i. Cash- Current Months Income
ii. Retro-Active lump sum payments from SSA/SSI
iii. Irrevocable Trusts
iv. Funds associated with Burial Insurance, Burial Plots, Irrevocable Burial Funds

d. Medi-Cal Certified/ Retro-active lump sum payment from SSA/SSI

i. Retroactive benefit payments from Title II (RSDI) and Title XVI (SSI/SSP) are not included in the property reserve for a period of nine (9) months following the month in which the payment is received. This rule applies to persons eligible for Medi-Cal under the Pickle Amendment, Disabled Adult Child(ren), Disabled Widow(er)s, Medically Needy/Medically Indigent Programs and other programs following Medically Needy Property rules. (The Social Security Protection Act of 2004)

e. Irrevocable Trusts

i. The A&E Laguna Honda financial counselor interviews resident or their representative to screen for possible income and assets. Any information or documentation related to the resident's trusts will be referred to the Medi-Cal Program eligibility worker and used for the purpose of eligibility determination.

f. Irrevocable Burial Funds

i. An individual may have both an exempt irrevocable burial fund (any amount) and an additional $1500 in an exempt revocable burial fund. Designated burial funds include burial trusts, prepaid burial contracts, burial insurance, annuities, or any separately identifiable assets which are clearly designated as set aside for expenses connected with the individual's burial, cremation or other funeral arrangements. Designated burial funds must be separately identifiable funds that are clearly designated for burial expenses. Savings or checking accounts, stocks, bonds, certificates of deposit and other financial instruments with a definite cash value may be exempted if designated as a burial fund. However, other Non-liquid assets, such as a car or real property, cannot be designated for burial expenses. Interest earned on or appreciation in value of a revocable burial fund shall be exempt if it is allowed to accumulate and become part of the separately identifiable burial fund.

3. **Steps for Review and Spend-Down of Assets in Laguna Honda Trust Account:** The A&E financial Counselor generates the Resident's Fund Balances Report (Spend-down Report) on the 15th of each month.

   a. Resident or residents' representative (including Conservative or Payees) manages funds: The A&E Laguna Honda financial counselor will notify the resident or the resident's legal representative when the trust fund account reaches $1500.00 dollars. If the resident is incapable of making financial decisions, the resident's representative will be notified by telephone and /or mail.

   b. Medical Social Worker (MSW) manages residents' funds: If the resident is unable to manage his/her funds and the resident does not have a legal representative, unless otherwise designated the MSW is responsible for managing the residents trust account. The A&E financial counselor will take the following steps to monitor the trust account balance, and spend-down when the balance is near the Medi-Cal personal property limit.

      i. When residents' trust fund accounts reaches $1500.00, the A&E financial counselor will notify the resident's MSW of spend down request via email and copy the nurse manager and A&E supervisor.

      ii. When the residents' trust account reaches $19001700.00, the A&E financial counselor will send another the 2nd request for spend down via email to the MSW and Nurse Manager. . A copy of email stating second request will be sent the Director of Social Services, Nursing Director, and A&E Manager, CNO and CFO.

      iii. The social worker and nurse manager will assess the resident's personal needs and make the necessary purchase on behalf of the resident to reduce the personal property.

iv. After 30 days, and there is If no spend-down of funds after second notification, the Laguna Honda A&E financial Counselor will send notification (see attached notice of spend down notices) to all persons listed in section 9b-ii. A separate email is sent to the billing department to inquire on patient accounting balances.

v. If no purchase(s) or payment is made to reduce the trust account, the financial counselor will prepare the authorization to cashiers for release of the resident's funds to California Department of health Services, Recovery Section.

vi. The cashier's office will issue a check, which the Laguna Honda A&E financial counselor will include a copy of the check in the residents A&E file and mail the check to California Department of health Services, Recovery Section MS 4729, P.O. Box 997421, Sacramento, CA 95899-7421.

vii. The A&E supervisor will review the ADL balance report to monitor spend-downs during the third week of the each month.

4. Spend-down of Resident's funds to Purchase Durable Medical Equipment:

a. Resident's funds may be used to purchase Durable Medical Equipment (DME) for the exclusive use of the resident.

b. Resident's funds may be used to purchase Durable Medical Equipment not covered by Medi-Cal, which includes wheelchairs, wheelchair positioning devices, orthopedic shoes, etc.

c. A referral for a formal evaluation shall be completed by the resident's physician and submitted to the Rehabilitation Department.

d. If the resident needs DME, the Rehabilitation Professional (OT, PT, or ST) will contact the vendor to get a quote for the equipment.

e. The social worker will contact the A&E financial counselor for the resident's trust account balance. If the resident has funds, an MD order is faxed to the vendor.

f. Once the vendor provides the quote, the Rehabilitation Department contacts the MSW for final approval.

g. Once approved by the MSW and the funds and authorization are received from the A&E department, the Rehabilitation Department will place the order for DME with the vendor.

h. The Rehabilitation Department coordinates with the vendor for delivery and final fitting of the DME.

ATTACHMENT~~S~~:
Attachment A, B, C: Internal Memo from E.W. to Department Heads of Nursing, Social Services, CNO,CFO and Admissions Manager/Supervisor

REFERENCE~~S~~:
Medi-Cal Eligibility Manual – Procedures Section

Revised: 12/05/22, 16/01/12 (Year/Month/Day)
Original adoption: 10/08/24 ~~(Year/Month/Day)~~

Attachment A: 1st Request Memo from E.W. to Nursing Manager and MSW

Date:

From:

To:

Re: Release of Patient's Funds to DHS-Medi-Cal Recovery Unit

Resident's trust fund account has reached $____________.

The Medi-Cal Program allows a maximum of $2,000.00 personal property limit for a single adult in a family budget unit.

Eligibility is initiating a spend-down on the above resident. Please spend-down $200, otherwise LHH will return the excess money to Calif. Dept. of Health Services.

Cc: MSW, Nurse Manager

Attachment B: Spend down 2nd Request

Date:

From:

To:

Re: **Spend down request memo from A&E to Department Heads of Nursing, Social Services (2nd Request):**

Resident's trust fund account has reached $____________.

The Medi-Cal Program allows a maximum of $2,000.00 personal property limit for a single adult in a family budget unit.

Eligibility is initiating a spend-down on the above resident. Please spend-down $200, otherwise LHH will return the excess money to Calif. Dept. of Health Services.

Cc: Nurse Manager, Nursing Director, MSW, CFO, CNO, A&E Supervisor and Manager

Attachment C: 3rd Internal Memo from E.W. to Department Heads of Nursing, Social Services, and Admissions:

Date:

From:

To:

Re: Release of Patient's Funds to DHS-Medi-Cal Recovery Unit (Final Notice)

Resident's trust fund account has reached $___________.

The Medi-Cal Program allows a maximum of $___________ personal property limit for a single adult in a family budget unit. The resident's Social Worker and Nurse Manager have indicated that resident currently has no personal needs.

To reduce the residents trust account, an amount of $200.00 has been withdrawn from the trust account and forwarded to the Medi-Cal Recovery Unit -.California Department of Health Services

cc: Cc: Nurse Manager, Nursing Director, MSW, CFO, CNO,

PATIENT SAFETY COMMITTEES AND PLANS

POLICY:

Pursuant to SB 158 and Health and Safety Code §1279.6 Laguna Honda Hospital and Rehabilitation Center shall establish an annual patient safety plan to improve patient/resident safety and reduce patient/resident suffering resulting from preventable events.

PURPOSE:

The purpose of establishing an annual patient safety plan is to implement a systematic and comprehensive process for reviewing patient/resident incidents and conducting thorough analyses of reported patient safety events.

PROCEDURE:

1. Patient Safety Committees

a. The Acute Care ~~Hospital-wide~~ Performance Improvement and Patient Safety (PIPS) Committee shall serve as the Patient Safety Committee that reviews patient safety events that occur on the acute care units of the facility.

b. The Skilled Nursing Facility (SNF) ~~Hospital-wide~~ Performance Improvement and Patient Safety (PIPS) Committee shall serve as the oversight Patient Safety Committee for the five performance improvement committees/teams that focus on resident safety incidents that occur on the skilled nursing facility units.

c. The Skilled Nursing Facility performance improvement committees/teams that address patient safety events include the following:

~~i. Environmental Health and Safety Committee~~

~~ii.~~i. Falls and Restraint Performance Improvement Team

~~iii.~~ii. Medication ~~Incident Review Committee~~Error Reduction Sub-committee

~~iv.~~iii. Pressure Ulcer Prevention Performance Improvement Team (formerly known as the Wound Care Advisory Council)

~~v.~~iv. Resident Safety and Abuse Prevention Performance Improvement Team

~~vi.~~v. Occupational Safety and Health

d. The Infection Control Committee shall submit, at a minimum, quarterly reports to the Patient Safety Committee (i.e. Acute Care and ~~Skilled Nursing Facility Hospital-wide Performance Improvement~~ SNF PIPS Committees).

d.e. Serving as Patient Safety Committees, the composition and functions of the Acute Care and SNF PIPS Committees are described under Procedures 3 and 4 below.

2. Reporting System for Patient/Resident Safety Events

a. The Unusual Occurrence system is the reporting system that is used to report actual and potential patient safety events, excluding individual patient/resident infections.

b. The Infection Control surveillance program is the reporting system for reporting actual and potential health-care-associated infections or health-care acquired infections (HAIs).

c. The definition of a patient safety event includes all adverse events or potential adverse events that are determined to be preventable and health-care-associated infections, as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee, that are determined to be preventable.

3. Composition of the Patient Safety Committee

The Patient Safety Committee comprises of various health care professionals including, but not limited to the following members:

a. Physicians

b. Nurses

c. Pharmacists

d. Administrators or designees

e. Other staff members with appropriate competencies to participate in the review of patient safety events

4. Functions of the Patient Safety Committee

The Patient Safety Committee is responsible for performing the following functions:

a. Review, approve and revise the patient safety plan, at least once a year, but more often if necessary to evaluate and update the plan

b. Receive and review reports of patient safety events during the Acute Care and Skilled Nursing Facility Hospital-wide Performance Improvement Committee meeting

c. Provide oversight that the significant or sentinel event process is being carried out according to facility policies and procedures, ensuring that:

   i. an interdisciplinary investigation team has been assigned to conduct an in-depth review and perform a root cause analysis; and

   ii. the investigative team develops corrective measures, with timeline for implementation of the corrective measures, and the persons responsible.

d. Monitor the status and implementation of corrective actions for patient safety events on a monthly basis until complete

e. Make recommendations to eliminate future patient safety events by supporting processes that encourages:

   i. a culture of safety

   ii. the reporting of patient safety events

   iii. interdisciplinary collaborative processes for improving the delivery of safe patient care

   iv. prioritization of safety initiatives

   v. on-going patient safety training for facility personnel

ATTACHMENT:
None.

REFERENCE:
Senate Billl 158
Health & Safety Code Safety Code §1279.6
LHHPP 60-01 Performance Improvement Program
LHHPP 60-04 Unusual Occurrences
LHHPP 60-12 Sentinel and Significant Events

Revised: N/A16/01/12 (Year/Month/Day)
Original adoption: 10/11/10 (Year/Month/Day)

CODE SILVER – ACTIVE SHOOTER

POLICY:

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

PURPOSE:

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

DEFINITION:

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

PROCEDURE:

1. Situation

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

2. Employee Responsibility

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

a. Being familiar with the work area;

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

c. Having a plan for barricading in place.

3. General Response – Run…Hide…Fight

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

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

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

4. If a Shooter Enters Your Work Area

a. Run to safety if possible.

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

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

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

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

i. Commit to your decision and act as aggressively as possible toward the shooter.

ii. Improvise weapons using things like fire extinguishers or sharp instruments.

iii. Yell and throw things at the shooter.

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

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

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

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

c. Leave your belongings.

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

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

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

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

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

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

6. Notification and Incident Command

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

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

   i. Location and description of the shooter(s)

   ii. Number of shooters and number and type of weapons

   iii. Number of victims and/or hostages

b. If you call 911, the dispatchers will notify the Laguna Honda Sheriffs immediately.

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

d. The SFSD staff will announce via overhead page:

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

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

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

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

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

ATTACHMENT:
None.

REFERENCE:
Laguna Honda Hospital Code Silver Active Shooter Response Guide *(pocket guide)*
The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Partnership's "Active Shooter Planning and Response in a Healthcare Setting", Draft January 2014.

Revised: 16/01/12 (Year, Month, Day)N/A
Original adoption: 15/07/14

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

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

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

No Hospital Command Center Activation & No DOSRs Until Shooter Apprehended

Remain Barricaded Until You Are Given Further Instructions.

Laguna Honda Hospital

Code Silver

Active Shooter Response Guide

BE PREPARED TO DEAL WITH AN ACTIVE SHOOTER SITUATION:

Be aware of your environment.

Be vigilant regarding any unusual or suspicious activities.

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

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

IF A SHOOTER ENTERS YOUR VICINITY:

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

IF THE ACTIVE SHOOTER IS NOT AT YOUR LOCATION:

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

IF YOU ARE OUTSIDE:

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

WHEN POLICE ARRIVE:

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

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

AFTER A SHOOTING INCIDENT:

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

Fire Drill

POLICY:

1. Laguna Honda Hospital will conduct a minimum of one Fire Drill per building or zone occupied by residents (e.g. in the North, South and Pavilion buildings) each month on rotating shifts for a total of 3 drills per month to reach each shift at least quarterly.

2. Fire Drills will be scheduled by the hospital's Fire Safety Officer (FSO), in cooperation with appropriate department managers, however the drills will be randomly conducted and unannounced to staff prior to the drill.

3. It shall be each department manager's responsibility to understand and comply with Fire Drill procedures, and to require staff participation in all Fire Drills.

4. Department managers are responsible for assuring that their employees receive Fire Safety Training as part of new employee orientation and annually thereafter. The Fire Safety Officer (FSO) is available as a resource to provide training as necessary.

5. Telecommunications calls are forwarded to the Nursing Operations Manager, who will assume the telecommunications duties described herein, during the night shift or when the operator is on break.

PURPOSE:

Fire drills are conducted regularly so that staff are familiar with Code Red procedures and can readily respond in case of an actual fire in the facility.

PROCEDURE:

1. The FSO or designee will prepare a quarterly drill schedule identifying the locations and times of the drills. This schedule will be submitted to the Executive Administrator and Associate Administrator of Operations.

2. The FSO will advise the telecommunications operator of the time and location of the Code Red Drill, will call DTIS (monitoring service) to notify them that the City Tie will be deactivated during a drill, and will deactivate the City Tie, allowing for drill participants to activate a manual pull station without sending an actual alarm to the Fire Department.

3. Upon notification of a Code Red Drill by the FSO or designee, hospital staff are to take the following actions:

   Follow the R.A.C.E. acronym below for basic fire response steps:

i. **R**escue persons in immediate danger while announcing "Code Red" to nearby staff.

ii. **A**larm by pulling the lever on the nearest manual pull station and Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name

iii. **C**ontain the smoke and/or fire by closing all windows and doors and direct others to assist you.

- State that you would move residents needing oxygen to a safe area to administer it.
- Licensed staff simulates turning off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.
- State that you would turn off electrical equipment in the area.

iv. **E**xtinguish: Extinguishers are located in corridors and units throughout the facility. Extinguishers are used according to the P.A.S.S. acronym (Simulate):

- **P**ull the pin
- **A**im at the base of the fire
- **S**queeze the handle
- **S**weep side to side

b. Department managers and Nurse Managers are responsible for ensuring that employees have knowledge of the fire extinguisher locations.

c. North Mezzanine (NM) exception: North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:
i. **N1:** send staff to monitor NM **Cypress** household door
ii. **N2:** send staff to monitor NM **Redwood** household door
iii. **N3:** send staff to monitor NM **Cedar** household door
iv. **N4:** send staff to monitor NM **Juniper** household door
Staff must proceed via stairs to NM with caution: Do Not open door if warm/ hot to touch or if smoke is seeping through.

4. Staff in areas of the hospital other than the drill location shall simulate a Code Red Drill in their department. The department supervisor will complete the Fire Drill Participation form, include signatures of staff, and will forward it to the Fire Safety Officer. For night shift drills, National Fire Protection Administration Life Safety code permits silencing of chimes; staff are alerted to the drill by overhead announcement.

5. The FSO or designee will advise PBX when the fire drill is concluded. The PBX operator will announce "Code Red Drill All Clear" three times over the public address system, and will transmit the same message via radio to all radio units. The FSO may disable the chimes for night shift drills, however, the overhead announcement will still be made.

6. All Department Managers, Nurse Managers or designees shall complete the Fire Drill Participation form, and fax it to the Fire Safety Officer in Facility Services at 759-2330 within one hour of the drill. The FSO will record departmental/ward participation and report results to Division Heads and to the Safety Committee. The FSO will complete a separate form for the drill location. All forms will be placed on file for annual review by the State Fire Marshal.

7. The FSO will advise the telecommunications operator that the Code Red Drill is clear, will call DTIS to notify them that the City Tie is being reactivated, and will reactivate the City Tie.

ATTACHMENT:
Appendix A: Laguna Honda Hospital Fire Drill Fire Safety Officer's Drill Record
Appendix B: Laguna Honda Hospital Fire Drill Participation Form

REFERENCE:
CCR, Title 22, Sections 70743, 70745 and 72553
CCR, Title 19, Section 3.09. San Francisco Fire Code, Sections 12.201 through 12.204
NFPA Life Safety Code 101 (2009 edition), Chapter 19, paragraph 19.7.1.7.

Revised: 13/01/29, 16/01/12 (Year/Month/Day)
Original adoption: 11/09/27 (Content derived from 71-02 Fire Response Plan)

Appendix A

LAGUNA HONDA HOSPITAL FIRE DRILL
FIRE SAFETY OFFICER'S DRILL RECORD

1. Drill Location: ________________________ Date: __________________________

2. Time: ___________AM/PM Shift: Day _____ Swing _____ Night ______

3. Procedures Implemented:

   a. Declare Code Red Drill? Yes ( ) No ( ) Time __________ AM/PM
   b. Activate the fire alarm? Yes ( ) No ( )
   c. Call operator 4-2999? Yes ( ) No ( )
   d. Operator announce "Code Red Drill (location)"? Yes ( ) No ( )
   e. Operator simulated call to 911? Yes ( ) No ( )
   f. Close doors and windows? Yes ( ) No ( )
   g. Take extinguisher to fire? Yes ( ) No ( )
   h. Simulate evacuating individuals from danger? Yes ( ) No ( )
   i. Staff from adjacent wards reported for assistance? Yes ( ) No ( )

4. Watch Engineer respond? Yes ( ) No ( ) Time __________ AM/PM

   a. Simulate securing ventilation? (If applicable) Yes ( ) No ( )

5. Institutional Police respond? Yes ( ) No ( ) Time __________ AM/PM

6. Time drill terminated. Time __________ AM/PM

7. Rating of drill (check one). Explain basis for rating in comment section below. Drills are rated on how well staff performs.

   Excellent __________Fair __________ Good __________ Poor __________

8. Comments:

9. If performance on drill is fair or poor, please submit your plan of correction to the Executive Administrator's office for review within 1 week of drill date.

10. Fire Safety Officer_____________________________ Date:_____________

cc: Unit/Department Manager
Executive Administrator
Director of Nursing
Assistant Director of Nursing
Associate Administrator – Operations
Safety Committee Chairperson

Appendix B

LAGUNA HONDA HOSPITAL
FIRE DRILL PARTICIPATION FORM

Instructions: This form must be completed by **ALL** Units and faxed to the Fire Safety Officer at 759-2330 in Facility Services, **within one hour of completion of the drill.** This form should be completed even if the fire drill is not conducted in your work area. Your staff should actively participate in every fire drill.

1. Your Department/Location:___________________________
   Date:_______________________
   (NOT the location of drill)

2. Time:________________________(AM/PM) Shift: Day_____ Evening _____
   Night_____

3. Procedures implemented.
   Chimes and strobes are not activated for fire drills between the hours of 9pm-6am.

	Review Criteria	**YES**	**NO**	**N/A**
a.	Was Code Red Drill announcement heard over paging system?			
b.	Were the chimes audible? ____________			
c.	Were the Strobe lights visible? ______________ ______			
d.	Did fire smoke doors held by electromagnets close? ______			
e.	Did staff simulate closing doors and windows? ______			
f.	Did staff simulate turning off oxygen and any electrical equipment? ___________			
g.	Did staff simulate controlling a fire? __________ ______			
h.	Are staff familiar with patient and visitor evacuation procedures including those residents with oxygen? ______			

4. Comments:

5. Participants are to PRINT own name and classification:

EMPLOYEE NAME	**CLASSIFICATION**

-------------------PLEASE DO NOT WRITE BELOW ---- FOR FACILITIES USE ONLY------------------

6. ____

Facilities Review by: Date: Signature

7. Problems identified from **a** thru **d** to be followed up by facilities:

8. Problems from **e** thru **h** to be followed up by Nurse Managers:

~~**LAGUNA HONDA HOSPITAL**~~
~~**FIRE DRILL PARTICIPATION FORM**~~

~~Instructions: This Form to be completed by all Units and departments and faxed to the Fire Safety Officer at 759-2330 in Facility Services, within one hour of completion of the drill. This form should be completed even if the fire drill is not conducted in your work area. Your staff should actively participate in every fire drill.~~

~~1. Department/Location: ______________________________ Date: _________________~~
~~(NOT the location of drill)~~

~~2. Time: ____________AM/PM Shift: Day ________ Swing _______ Night ______~~

~~3. Procedures Implemented:~~

~~a. Was Code Red Drill announcement heard over paging system? Yes ( ) No ( )~~
~~b. Were the chimes audible? Yes ( ) No ( )~~
~~c. Strobe lights visible? Yes ( ) No ( )~~
~~d. Did fire smoke doors held by electromagnets close? Yes ( ) No ( )~~
~~e. Did staff simulate closing doors and windows? Yes ( ) No ( )~~
~~f. Did staff simulate turning off oxygen and any electrical equipment? Yes ( ) No ( )~~
~~g. Did staff simulate controlling a fire? Yes ( ) No ( )~~
~~h. Are staff familiar with patient and visitor evacuation procedures including those residents with oxygen? Yes ( ) No ( )~~

4. Comments:

5. Participants: (Please lists all staff in department who participated)

6.1. Department Manager: ___________________________ Date: ___________________

GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

POLICY:

Laguna Honda Hospital shall adopt the prevention and control of tuberculosis (TB) guidelines that were developed by the California Department of Health Services Licensing and Certification Program, the Tuberculosis Control and Infectious Diseases Branches of the Division of Communicable Disease Control and the California Tuberculosis Controllers Association (CDPH –CTCA Joint Guidelines) to minimize resident and health care worker exposure to tuberculosis.

Website address: http://www.cdph.ca.gov/programs/hai/Documents/Guidelines-Prevent-Control-TB-California-LT-HCF-2013.pdf

~~Managers are responsible for follow up on annual TB screening non-compliance reported to them by the LHH Clinic charge nurse/ designee.~~

DEFINITION:

Health care workers (HCWs) are defined as persons, paid and unpaid, working in health care settings who have direct contact with residents or who work in resident care areas.

PURPOSE:

The purpose of these guidelines are multi-fold and include the following:

1. Design and implement a program for screening residents and health care workers for TB;

2. Reduce the transmission of TB through prompt detection and management of active tuberculosis disease;

3. Establish a process for requesting consultation from the local health department in the investigation and management of active TB disease; and

4. Comply with Federal, State and City regulations.

PROCEDURE:

1. Tuberculosis Skin Test (TST)

a. The TST is performed using the Mantoux method of intradermally injecting five (0.1cc) tuberculin units of purified protein derivation (PPD) into the volar aspect of the forearm.

b. A two-step TST shall be administered to residents and HCWs who have never been tested, or if more than 12 months have elapsed since the last documented negative TST. The second TST shall be administered within 1 to 3 weeks after the first if the first TST is interpreted as negative. The results of the second TST shall be the reported result.

c. In uninfected persons, a positive result on any future TST shall be interpreted as a skin test conversion.

d. New residents and HCWs with positive TST results shall be referred to their healthcare provider or the local health department for treatment recommendations.

e. Persons with a positive TST and prior BCG vaccine shall be considered to have latent tuberculosis infection (LTBI).

2. Screening Residents

a. New Admission and Annual Screening

i. Residents with no known or suspected TB shall be screened upon admission with a two-step TST and annual PPD test.

ii. Residents who have received the bacilli Calmette-Guerin (BCG) vaccine shall be included in the TST screening program.

iii. Residents who are known or suspected to have TB and are hospitalized or are residents of other healthcare facilities, may only be admitted with written approval of the local health department/ TB Clinic, or when they are no longer infectiou~~n~~s according to the criteria described in the CDPH –CTCA Joint Guidelines.

iv. A resident who has a documented history of positive TST or Interferon Gamma Release Assay (IGRA), or history of active TB disease, shall be screened for TB disease on admission with a symptom screen *(bloody sputum, hoarseness lasting 3 weeks or more, persistent cough lasting 3 weeks or more, unexplained excessive fatigue, unexplained persistent fever lasting 3 weeks or more, unexplained excessive night sweats, unexplained weight loss)* and chest x-ray (CXR), unless one was already done in the United States within 90 days prior to admission.

v. Residents who have documented history of positive TST or IGRA, or history of active TB disease shall be screened annually and if a change in condition suspicious of TB disease occurs. TB screening will include a symptom screen and CXR, if indicated.

If the result of the CXR is abnormal, the in-coming resident shall be referred to the healthcare provider for evaluation. The resident shall not be admitted until s/he receives medical clearance from -the local health department/ TB Clinic.

- ~~that s/he does not have infectious TB.~~

- If the resident has been admitted to the facility and has an abnormal CXR, the resident shall be placed in respiratory isolation. The case must be reported to the San Francisco TB Clinic within 1 business day. Per TB clinic recommendations, three sputum specimens shall be obtained for AFB smear and culture and treatment with an appropriate four~~4~~ drug TB regimen shall be initiated. ~~*(TB clinic site says to start tx even before AFB results are obtained.)*~~

b. Resident Conversions

i. Residents who convert from a negative to positive TST/IGRA result must have a symptom screen done on the same day. Asymptomatic residents shall have a CXR within 24 hours or by the next business day. Symptomatic residents shall be transferred to isolation and have a STAT CXR.

ii. If CXR result is negative, LTBI treatment will be offered and a symptoms screen will be performed annually.

iii. If CXR result is abnormal, the resident shall be placed in respiratory~~an~~ isolation ~~room~~. The case must~~will~~ be reported to TB Clinic within 1 working day. Per TB Clinic recommendations, ~~and~~ three sputum specimens shall be obtained for AFB smear and culture and t~~. T~~reatment with an appropriate four drug TB regimen shall be initiated. ~~will be ordered by the physician based on AFB results.~~ Respiratory isolation may be discontinued after 3 negative AFB smears are obtained, five days of TB treatment is completed, and if the resident is no longer symptomatic. A physician's order shall be obtained to discontinue respiratory isolation.

iv. A contact investigation ~~may be required. Contact infection control for guidance.~~for residents and staff will be conducted per LHHPP 72-01 Infection Control Manual, A9 Contact/ Exposure Investigation.

c. Re-admission Screening

i. Residents who are re-admitted to the facility within 90 days of discharge requires a TB symptom screen.

ii. Residents who have been discharged for longer than 90 days and are re-admitted require a TB screen based on prior TST status.

3. Screening Health Care Workers (HCWs)

a. New Hire and Annual Screening

i. HCWs shall be screened for tuberculosis within 90 days prior to work, and annually thereafter.

ii. HCWs with no known or suspected TB shall be screened prior to work with a two-step TST and annual PPD test.

iii. HCWs who have received the bacilli Calmette-Guerin (BCG) vaccine shall be included in the TST screening program.

iv. HCWs with documented history of positive TST/IGRA, or history of active TB must have a TB symptom screen and CXR performed unless the HCW provides a written report of a negative CXR done in the United States performed within the past 90 days.

v. HCWs with TB symptoms *(bloody sputum, hoarseness lasting 3 weeks or more, persistent cough lasting 3 weeks or more, unexplained excessive fatigue, unexplained persistent fever lasting 3 weeks or more, unexplained excessive night sweats, unexplained weight loss)* must have a new CXR performed as soon as possible to rule out active TB disease.

vi. If results of the CXR is abnormal, the HCW must be promptly referred to their healthcare provider for evaluation and may not be permitted to work until s/he is determined not to have infectious TB. Written medical clearance must be provided.

vii. HCWs with a positive TST/IGRA, normal CXR and no history of treatment for latent TB infection shall be encouraged to see their healthcare provider prior to employment for evaluation and treatment recommendations.

viii. HCWs with a history of active TB disease must provide documentation of completion of an adequate course of treatment and have medical clearance prior to work.

ix. HCWs will receive a ~~reminder~~ notification from the LHH Clinic when his or her annual ~~TB screening or~~ PPD test or TB screening is due. A list of staff who are due for ~~TB screening or~~ PPD test or TB screening will be sent by the designated LHH Clinic nurse to department ~~heads and~~ managers each month. Department ~~heads and~~ managers are responsible for follow up on annual PPD test or TB screening non-compliance reported to them. ~~shall ensure that staff are up to date with annual TB screening or PPD test,~~ HCWs who are non-compliant ~~more than 6 months overdue for th~~for their ~~ei~~overdue ~~forr~~ annual PPD test or TB screening ~~or PPD test~~ will ~~receive progressive discipline.~~be followed up according to Human Resources protocols. ~~may not continue to work until TB screening is up to date.~~

b. HCW Conversions

i. HCWs who convert from a negative to positive TST/IGRA result during employment must have a TB symptom screen and a CXR within one week and be promptly referred to a healthcare provider or the local health department for treatment recommendations.

ii. Symptomatic HCWs must be excluded from work until active TB disease is ruled out and written medical clearance is provided.

c. Post-Exposure Screening

i. HCWs who have been exposed to a confirmed case of active pulmonary TB must receive a symptom-screen questionnaire.

ii. Symptomatic HCWs must have a CXR immediately and referred for medical evaluation.

iii. If a HCW is asymptomatic and has a negative TST/IGRA within the past 3 months of exposure to a confirmed case of active pulmonary TB, the HCW shall be tested in 8-10 weeks following exposure.

iv. If a HCW is asymptomatic and has a negative TST/IGRA greater than 3 months of exposure to a confirmed case of active pulmonary TB, the HCW shall be (TST/IGRA) tested as soon as possible, and the test repeated in 8-10 weeks following the last exposure.

4. Reporting of Positive TSTs

a. Residents or HCWs who test positive following initial negative results upon admission or hire are classified as converters and shall be reported to the local health department. ~~(are reporting and referrals different? TB Clinic does not accept referrals for positive TST, normal cxr, and symptomatic)~~

b. HCW TST conversions shall also be recorded on the OSHA 300 log. ~~(Is the OSHA 300 log kept by Kate? I do not think she keeps this information)~~

c. The local health department or CDPH shall be consulted as necessary when there are questions related to implementation of the written guidelines.

5. Record Keeping and Retention

a. Effective January 2016, r~~R~~esident admission and annual TST result or TB symptom screen shall be entered and maintained in his or her electronic health record. Nurses ~~and physicians shall~~will enter PPD results and physicians will enter TB symptom -review ~~data according to their respective department protocols.~~
~~-records shall be maintained in the clinical health record according to health record retention requirements. Admission and annual TB symptom screen, and TST results shall be entered into Electronic Clinical XXXX Works (eCW).~~

b. Paid HCW health records shall be maintained for the duration of employment plus 30 years.

~~a.~~c. Unpaid HCW health records shall be maintained for the duration of service plus 7 years.

6. Training and Education

a. HCWs shall be trained annually in methods to identify, prevent and control the transmission of TB.

b. Training shall be conducted by a health care professional based on current literature and include the topics required by Cal/OSHA.

c. Training records shall be maintained for a minimum of 3 years from the date the training occurred.

7. Quality Assurance and Performance Improvement

a. Resident TB screening data for one neighborhood in each building (North and South towers) will be reviewed annually. If 90% or more of the screenings are not completed, TB screening data for all other neighborhoods will be reviewed.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, A9 Contact/ Exposure Investigation
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan
CDPH-CTCA Joint Guidelines for Prevention and Control of Tuberculosis in California Long Term Health Care Facilities
SFDPH Communicable Disease Control and Prevention, TB Control, Information for Medical Providers available http://sfcdcp.org/tbinfoforproviders.html

Revised: 05/11/01, 15/11/09, 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

STANDARD PRECAUTIONS

POLICY:

1. ~~1.~~ Laguna Honda Hospital (LHH) employees will ~~will~~ practice Standard Precautions that include: 1) hand hygiene, 2) use of personal protective equipment (PPE), 3) safe injection practices, 4) safe handling of potentially contaminated equipment or surfaces, and 5) respiratory/cough etiquette.

~~1. Clinical staff will use Standard Precautions (hand hygiene, use of personal protective equipment and environmental controls) in the care of all residents to reduce the risk of transmission of potentially pathologic microorganisms,~~

2. ~~2.~~ Standard Precautions apply to potential contact with all body fluids ~~(including blood)~~, ~~, all secretions and excretions, all~~ non-intact skin, ~~(including~~ rashes, and ~~to all~~ mucous membranes.

3. ~~3.~~ Clinical staff will use Standard Precautions for the care of all residents regardless of known diagnoses ~~T~~to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. ~~, clinical staff will use Standard Precautions for the care of all residents without regard to diagnosis.~~ The epidemiologic foundation for the use of Standard Precautions is that the sources for many microorganisms associated with healthcare-associated transmission are colonized body sites of patients in whom infection is neither diagnosed nor suspected.

PURPOSE:

To prevent~~interrupt~~ the spread of infection by all routes likely to be encountered in the health- care setting, Standard Precautions, established by the Centers for Disease Control and Prevention (CDC), are implemented at LHH.

~~BACKGROUND INFORMATION:~~

~~Standard Precautions (SP) is an infection prevention system has been implemented at LHH. Standard Precautions are designed to prevent exposure to all potentially infectious body substances and are NOT based on specific resident diagnoses.~~
~~The epidemiologic foundation for the use of SP is that the sources for many health care associated infections are microorganisms from colonized body sites of a resident in which infection is neither diagnosed nor suspected.~~
~~No special signs or alerts are necessary for implementation of Standard Precautions. Standard Precautions, when practiced consistently, will reduce the risk of transmission from direct or indirect contact with infectious materials.~~
~~a. Direct-contact transmission involves "touch" contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person. b. Indirect-contact transmission involves contact of a susceptible host with a contaminated surface or inanimate object.~~

~~Enhanced Standard Precautions (ESP) integrates and consolidates the CDC~~

recommendations for Standard Precautions with many of the recommendations for Transmission-based Precautions and Intensified Interventions. (See appendix for full report from California Department of Public Health. (http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-10-27-Attachment-Included.pdf)

PROCEDURE:

1. HAND HYGIENE AND PERSONAL PROTECTIVE EQUIPMENT (PPE)

Hand hygiene: Hands are to be washed with antimicrobial soap and water when visibly soiled or after caring for residents with known or suspected infectious diarrhea (e.g. Clostridium difficile, norovirus). Otherwise, hands may be cleaned usingwith alcohol-based hand rub. when hands are not visibly soiled. Hand washing must be performed when caring for residents with known or suspected infectious diarrhea (e.g. Clostridium difficile, norovirus) for effective removal of spores from the skin.

Hands are to be washed with soap and water or cleaned with alcohol-based rub after contact with blood, body fluids, excretions, secretions, non-intact skin, mucous membranes, or potentially contaminated physical items.

Hand hygiene must be performed immediately:

a. before and after contact with a resident or resident's surroundings
b. before performing an aseptic task
c. after contact with blood, body fluids, excretions, secretions, non-intact skin, rashes, mucous membranes, or potentially contaminated physical items
d. between tasks and procedures on the same resident to prevent cross-contamination of different body sites (e.g., after perianal care, oral care, respiratory care procedures, or after care of any infected sites)
e. before and after the use of gloves

i. Hands are to be cleaned immediately before and after the use of gloves and between resident contacts, and between tasks and procedures on the same resident to prevent cross-contamination of different body sites (e.g., after perianal care, oral care, respiratory care procedures, or after care of any infected sites).
ii. The use of gloves is never a substitute for meticulous hand hygiene.

2. 3PERSONAL PROTECTIVE EQUIPMENT (PPE)

a.b. **Gloves use:** Clean gloves must be worn when a potential risk for exposure to body fluids exists.

Gloves: Clean gloves are to be worn when touching blood, body fluids, excretions, secretions, and contaminated items.

i. Hands are to be cleaned immediately before and after glove use to prevent the transfer of microorganisms.

ii. Clean gloves must be put on prior to contact with blood, body fluids, ~~excretions, secretions~~rashes, ~~mucous membranes,~~ non-intact skin, mucous membranes,~~ rashes~~ or potentially contaminated items.

iii. Gloves must be worn when~~ever~~ using a "sharp" (e.g., ~~during~~when administering injections or using a razor). ~~Although gloves will not prevent needlesticks or other percutaneous exposures, a sharps injury that occurs through a glove may result in a reduced inoculum of the infectious body fluid.~~

iii. Gloves must~~are to~~ be changed and hands cleaned between tasks and procedures on the same resident, after contact with material that may contain ~~a high concentration of~~ microorganisms (e.g., after perianal care or respiratory care procedures, and~~ or~~ after care of any infected sites).

iv. Gloves are to be removed and hands cleaned promptly after use, before touching any non- contaminated items or surfaces, and before ~~going to~~ providing care to another resident.

~~v. Hands are to be cleaned immediately before and after glove use to avoidprevent the transfer of microorganisms.~~

~~i. Clean gloves must be put on just prior to touching mucous membranes or non-intact skin (e.g., prior to eye procedures or wound care).~~

~~ii. Gloves must be worn whenever using a "sharp" (e.g., during injections or phlebotomy). Although gloves will not prevent needle sticks or other percutaneous exposures, a sharps injury which occurs through a glove may result in a reduced amount of potentially infectious fluid being transmitted.~~

~~iii. Gloves are to be changed between tasks and procedures on the same resident, after contact with material that may contain a high concentration of microorganisms (e.g., after perianal care or respiratory care procedures, or after care of any infected sites).~~

~~iv. Gloves are to be removed promptly after use, before touching any non- contaminated items or surfaces, and before going to another resident.~~

~~v. Hands are to be cleaned immediately before and after glove use to avoid transfer of microorganisms.~~

~~c.~~

b. ~~Facemasks (Surgical or N95 Respirator Masks)~~**Mask/eye protection:**

A procedure (surgical) mask with eye protection or a face shield is ~~are~~ to be worn to cover~~protect~~ mucous membranes of the eyes, nose and mouth: ~~during:~~

~~procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions.~~

i. i. duringDuring procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions. Examples include: emptying drainage bags or suction canisters, passing nasogastric tubes, wound irrigation, intubations, and "open" system suction procedures, such as deep tracheal suctioning, and ANY other procedures in which
i.

ii.
ii. health care workers anticipate may place them at a risk for splash or splatter of body fluids exists.

iii. When caring for residents with suspected or confirmed droplet transmitted infections. Examples: RSV, IInfluenza, or Pertussis

A respirator mask (N95) and eye protection is to be worn to cover the mucous membranes of the eyes, nose and mouth when caring for residents with a suspected or confirmed airborne transmitted infections (e.g. Tuberculosis, Measles, or VaricellaSARS). Staff must be fit tested initially and annually to ensure proper respiratory mask type and size.

cd. **Plastic Aprons/Disposable Gowns:** Plastic aprons are to be worn to protect skin and to prevent contamination and soiling of clothing during close contact or procedures likely to generate splashes or splatter of blood or other body fluids. Disposable gowns are available for greater protection if needed.

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

3. SAFE INJECTION PRACTICES:

i. Health care workers are to take care to prevent injuries at all times and specifically:

- When using needles, scalpels, and other sharp instruments or devices
- When handling sharp instruments after procedures
- When cleaning and reprocessing used instruments
- When disposing of used needles and other sharps.

ii. Safety devices are used when appropriate.
iii. All health care workers using needle safety devices are to be educated regarding proper use on orientation and when a new device is introduced.
iv. Safety devices are to be activated immediately after use.
v. LHH strongly discourages the recapping of needles and in general, needles are not to be recapped.
vi. In the rare instance when recapping cannot be avoided, needles are NEVER to be recapped using both hands. Needle handling must never include any

technique that directs the point of the needle toward any part of the body.

vii. If needles must be recapped, a one-handed “scoop” technique is to be used, or a mechanical device is to be used to hold the needle sheath.

viii. Used needles are not to be removed from disposable syringes prior to disposal. Needles are not to be bent, broken, or otherwise manipulated by hand.

ix. Used disposable needles and syringes, scalpel blades, and other sharp items are to be disposed of immediately into the plastic, puncture-resistant “Sharps” containers, which are located close to the area in which the items are to be used. Sharps containers are to be replaced when ¾ full.

x. Careful selection of personal protective equipment (e.g., masks with eye shields) is to be used to prevent exposure to blood and other body fluids. Oral airways, ~~Mouthpieces,~~ resuscitation bags, and other ventilation devices are to be maintained in areas where the need for resuscitation is predictable. Direct mouth-to-mouth resuscitation is to be avoided.

4~~2~~. ENVIRONMENTAL CONTROLS

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

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

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

iii. All ~~other~~ resident care equipment that is used for multiple residents are~~is~~ to be designated for cleaning and disinfection on a regularly scheduled basis.

Refer to IC Manual Policy G5 *Transmission Based Precautions and Resident Room Placement.*

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

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

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

iii. E~~Some e~~quipment that has~~ve~~~~has~~ special disinfection guidelines, ~~which~~ are to be carefully followed.

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

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

d. **Resident Placement:** When a resident is newly admitted or relocated to a new bed, care is to be used to avoid transfer of microorganisms between residents.

~~i.~~ A resident who is infected or colonized with a multidrug-resistant organism (e.g. MRSA, VRE, CRE, ESBL, or C.diff) must be placed in a private room ~~with a~~and may require a private bathroom that is not shared with others. If a private room is not available, residents may cohort with a resident who is colonized with the same MDRO. Refer to IC Manual Policy C10 *Resident Room Placement Guidelines* for complete details.

.~~i.~~ A resident who does not, or cannot be expected to maintain appropriate hygiene and who contaminates the environment is to be placed in a private room, if possible.

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

~~**e. Occupational Health/ Blood borne pathogens:**~~

~~i. Health care workers are to take care to prevent injuries at all times and specifically:~~

- ~~When using needles, scalpels, and other sharp instruments or devices~~
- ~~When handling sharp instruments after procedures~~
- ~~When cleaning and reprocessing used instruments~~
- ~~When disposing of used needles and other sharps.~~

~~ii. Safety devices are used when appropriate.~~
~~iii. All health care workers using needle safety devices are to be educated regarding proper use on orientation and when a new device is introduced.~~
~~iv. Safety devices are to be activated immediately after use.~~
~~v. LHH strongly discourages the recapping of needles and in general, needles are not to be recapped.~~
~~vi. In the rare instance when recapping cannot be avoided, needles are NEVER to be recapped using both hands. Needle handling must never include any technique that directs the point of the needle toward any part of the body.~~
~~vii. If needles must be recapped, a one-handed “scoop” technique is to be used, or a mechanical device is to be used to hold the needle sheath.~~
~~viii. Used needles are not to be removed from disposable syringes prior to disposal. Needles are not to be bent, broken, or otherwise manipulated by hand.~~
~~ix. Used disposable needles and syringes, scalpel blades, and other sharp items are to be disposed of immediately into the plastic, puncture-resistant “Sharps” containers, which are located close to the area in which the items are to be used. Sharps containers are to be replaced when ¾ full.~~
~~x. Careful selection of personal protective equipment (e.g., masks with eye shields) is to be used to prevent exposure to blood and other body fluids.~~

~~Mouthpieces, resuscitation bags, and other ventilation devices are to be maintained in areas where the need for resuscitation is predictable. Direct mouth-to-mouth resuscitation is to be avoided.~~

5. RESPIRATORY HYGIENE / COUGH ETIQUETTE

Respiratory hygiene is essential in preventing droplet and airborne transmitted infections (e.g. RSV, influenza, and pertussis)

Cover your cough or sneeze each time by coughing or sneezing into a tissue. Dispose of the tissue in a trash receptacle. Wash hands with antimicrobial soap and water or clean hands using alcohol based hand rub. If a tissue is not available, cover your cough or sneeze with your sleeve.

ATTACHMENT:

~~None~~Appendix A: Recommendation for application of standard precautions for the care of all patients in all healthcare settings

REFERENCE:

LHHPP 72-01 Infection Control Manual, C4 Hand Hygiene
LHHPP 72-01 Transmission Based Precautions and Resident Room Placement
LHHPP 72-05 Employee Influenza Vaccination Policy and Use of Surgical Masks When Vaccination is Declined
APIC Text 3rd Edition 2009
Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Committee (HICPAC), 2007. Guideline for Isolation Precautions in Hospitals.
Occupational Safety and Health Administration (OSHA), 2012. Occupational Exposure to Blood borne Pathogens; Final Rule, Federal Register, 29 CFR Part 1910.1030.

California Department of Public Health, Enhanced Standard Precautions (ESP) for Long-Term Care Facilities, AFL 10-27, September 7, 2010 AFL 10, URL: http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-10-27-Attachment-Included.pdf
Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (CDC), 2014

Revised: 13/11/21, 16/01/12 (Year/Month/Day)
Original adoption: 2005/11

Appendix A:

RECOMMENDATIONS FOR APPLICATION OF STANDARD PRECAUTIONS FOR THE CARE OF ALL PATIENTS IN ALL HEALTHCARE SETTINGS

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

COMPONENT	**RECOMMENDATIONS**
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE)	
Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and non-intact skin
Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Mask, eye protection (goggles), face shield*	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.

Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, > 6 feet if possible.

TRANSMISSION-BASED PRECAUTIONS AND RESIDENT ROOM PLACEMENT

POLICY:

1. Resident room placement will meet the resident care infection prevention and control needs by providing the most appropriate room and bed assignment for every resident, as determined by his/her physician in collaboration with the care team and infection control.

2. Most diagnoses allow placement of residents into shared rooms and priority for single room placement will be based upon needs, including infection control requirements for transmission based precautions.

3. Residents with potentially communicable diseases, whether suspect or confirmed, will be assigned rooms according to the resident care precautions adopted by LHH. (See 72-01 Infection Control Policies and Procedures, Policy C1 Alphabetical List of Diseases/Conditions with Required Precautions.)

4. Resident care equipment should be dedicated to single resident use for residents with transmission based precautions and, if not feasible, equipment must be cleaned and disinfected before use by another resident.

5. Daily cleaning of rooms with transmission based precautions in place and terminal cleaning before a new occupant arrives shall be done in accordance with Environmental Services policies and Infection Control recommendations.

6. Food trays shall be delivered and removed wearing the appropriate PPE, cleaning hands and over bed table surface before setting tray down, and cleaning hands after tray removal. Disposable items are not required since the risk of transmission of pathogenic organisms from trays and dishes is minimal with proper cleaning and isolation measures.

PURPOSE:

To guide decisions regarding resident room placement to minimize the potential for disease transmission to others.

PROCEDURE:

1. Physicians and other clinical staff will assist in the appropriate placement of residents in collaboration with the Infection Control Nurse and Bed Control/ Patient Flow Coordinator Nurse.

2. Upon admission or relocation, the physician and other clinical staff will:

a. Identify those residents who may require Isolation Precautions prior to admission or relocation for proper placement.

b. Inform admitting personnel of residents who require isolation or precautions prior to transport in collaboration with the Bed Control/ Patient Flow Coordinator Nurse and infection control.

3. Inform residents / decision maker of potential isolation requirements and place appropriate signage available from the LHH forms site.

4. Assist visitors to follow precautions and explain visit restrictions, if any.

5. Provide a mask to the resident during transport if respiratory precautions for droplet or airborne pathogens are needed.

6. Consider the following to guide decisions regarding appropriate precautions and refer to specific disease/ condition policies for more information.

Transmission Based Precautions

7. Transmission Based Precautions may be warranted, **in addition to** consistent use of Standard Precautions, in certain situations for residents who are known or suspected to be colonized or infected with infectious agents, including pathogens that require additional control measures to prevent transmission.

8. Identify potentially infectious residents and institute Transmission Based Precautions as needed for suspected or confirmed infectious conditions including:

   a. Airborne Precautions

   b. Droplet Precautions

   c. Contact Precautions, which are “enhanced” for certain pathogens by the addition of bleach wipes to clean environmental surfaces and hand washing with soap and water.

9. Transmission Based Precautions shall be maintained for only as long as necessary to prevent the transmission of infection to achieve the least restrictive approach that adequately protects the resident and others.

10. Refer to the Alphabetical List of Diseases/ Conditions and Required Precautions and contact infection control to determine the appropriate precautions and the length of time the precautions should be maintained (72-01 Infection Control Policies and Procedures, Policy C1.). Infection control routinely checks CDC updates for revised recommendations.

11. **Airborne Precautions** are intended to prevent the transmission of organisms that remain infectious when suspended in the air. (e.g. Varicella, disseminated herpes zoster / Shingles, localized herpes zoster in immunocompromised residents, measles, pulmonary Mycobacterium Tuberculosis and other infectious conditions per Policy C1.)

    a. An Airborne Infection Isolation Room (AIIR), (formerly called negative pressure isolation room), providing 12 air changes per hour (ACH) is required for Airborne Precautions.

    b. Staff caring for residents on Airborne Precautions wear an N95 fit-tested mask or respirator that is donned prior to room entry in addition to PPE required for Standard Precautions. (Fit testing is required initially and annually.)

    c. Visitors may be offered an N95 mask in accordance with current CDC recommendations but should also be cautioned to limit the time spent in the isolation room, particularly in close proximity to a resident who is coughing. A surgical mask is also acceptable, since visitors are not fit tested for N95 masks and their close contact time with residents should be minimal.

    d. An AIIR (isolation room) is used at LHH for residents with confirmed or highly suspected influenza due to the high risk population. In this case, negative pressure and N95 masks are not needed. If an isolation room is not available, a private room or cohorting with resident(s) with like illness is acceptable.

12. **Droplet Precautions** are used for residents who have a known or suspected pulmonary disease that is spread by droplets and is unlikely to be TB. (e.g., including but not limited to bacterial pneumonia, *Pneumocystis carinii* pneumonia, and respiratory syncytial virus, per Policy C1.).

    a. Surgical masks are work by staff in addition to PPE required by Standard Precautions.

    b. A private room or cohorting residents with like infections is required.

    c. Consideration must be given to whether or not a private bathroom is also needed, since closed double and triple rooms have shared bathrooms. The goal is to keep persons 3-10 feet from one another since this is the distance for transmission of pathogens spread by droplets.

13. **Contact Precautions** are used in addition to Standard Precautions for specific infections, for potentially serious pathogens that are spread by direct or indirect contact with the resident or environment (e.g. antibiotic resistant infections such as MRSA, VRE, ESBL, CRE, *Clostridium Difficile* or infectious conditions with drainage that cannot easily be contained).

a. Contact precautions generally include placement in a private room (or cohorting of residents with like infections). Consideration must be given to whether or not a private bathroom is also needed, since closed double and triple rooms have shared bathrooms.

   i. For example, residents with Clostridium difficile infection should have a private bathroom due to pathogens potentially spread during toilet use and showering.

b. PPE includes gown and gloves for contact with both resident and their immediate environment.

c. Contact Precautions are **enhanced** with the use of bleach solution for environmental cleaning, bleach wipes for cleaning high touch surfaces (meaning frequently touched surfaces such as door knobs, faucet handles, side rails, etc.), and hand washing with soap and water (no alcohol based hand rub or wipes) for infections with highly contagious enteric pathogens / spores, such as Clostridium Difficile or Norovirus.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units
LHHPP 72-01 Infection Control Manual, Policy C1 Alphabetical Listing of Diseases/ Conditions with Required Precautions
CDC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, retrieved October 1, 2015
CMS, Centers for Medicare & Medicaid, 483.65 Infection Control (F441) Surveyor Training of Trainers Interpretive Guidance Investigative Protocol, retrieved June 26, 2015:http://www.healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/F441%20Infection%20Control.pdf

Original adoption: 16/01/12 (Year, Month, Day)

MEDICATION HANDLING/DISPENSING GUIDELINES

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) are responsible for the safe and effective requisition, storage, administration, and recording of drugs in the resident care areas in accordance with applicable state and federal regulations, JCAHO standards, Medical Staff Bylaws/Rules and Regulations, and hospital policy.

2. The Infection Control Committee (ICC) reviews administrative and nursing medication policies at least every two years or whenever changes occur.

PURPOSE:

The Infection Control program at Laguna Honda Hospital (LHH) reviews policies and guidelines for the storage, handling, and dispensing of medications to ensure the sterility and safe and consistent practices.

PROCEDURE:

1. Medications are administered via the following routes: oral, intravenous, intramuscular, subcutaneous, intradermal, ophthalmic, otic, nasal, vaginal, rectal, topical, and/or aerosolized via nebulizer or metered dose inhaler.

   Policies and procedures for administration of medications via any of these routes are available in the LHH Nursing Policies and Procedures Manual - Medication Administration J1.0, 2006.

2. The expiration date will always be checked prior to preparation and/or reconstitution of any medication.

3. Pharmacy fFollowsFollow the expiration date information provided in the LHH Pharmacy Policy and Procedure 02.01.06 Expiration Dating of Pharmaceuticals.

3.4. Registered Nurses may administer or titrate intravenous medications. Registered Nurses may add or superimpose medications to intravenous solutions. Licensed Vocational Nurses may monitor intravenous fluids to which medications have been added.

   a. Observe proper hand hygiene prior to any preparation activities.

   b. Inspect all IV bags/bottles/vials under good light for cracks/leaks. Inspect the solution for clarity. Return to the pharmacy DPS if any doubt.

~~4.~~5. All IV drip medications will be labeled by pharmacy or nursing with the name of the medication, and administered as specified in approved nursing policy or guidelines for administration of intravenous medications.

~~5~~6. Drugs shall be stored at appropriate temperatures. Refrigerator temperature shall be between 2.2°C (36°F) and 7.7°C (46°F) and room temperature shall be between 15°C (59°F) and 30°C (86°F).

~~6~~7. Drugs shall not be kept in stock after the expiration date on the label.

~~7~~8. Drugs maintained on the nursing unit shall be inspected monthly by pharmacy staff. Any irregularities shall be reported to the Nurse Manager or Nursing Supervisor.

Maintenance of Sterility and Retention/Expiration of Medications

9. Injectable medications and diluents:

   a. If single dose:

      i. Should be discarded after use.

      ii. Must be discarded within 24 hours of opening unless there is a specific exception, approved by pharmacy and infection control, and that exception is detailed in the nursing policy manual of the unit.

   b. Multi-dose vials of injectable drugs: Multi-dose vials of injectable shall be visually inspected prior to use and discarded if any of the following occur.

   c. There is a change in appearance of the solution.

   d. There is damage or loss of integrity of the closure.

   e. The drug has been improperly stored.

   f. The vial is known or to suspected to be contaminated.

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

   h. PPD vials shall be dated upon initial entry, refrigerated, and discarded after 28 ~~30~~ days.

   i. Insulin vials shall be dated upon initial entry and refrigerated. Open, in use-vials shall be discarded after 28 days. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

j. Injectable that contain preservatives (other than PPD and insulin) shall be:

i. Dated upon initial entry.

ii. Refrigerated for stability, if recommended by the manufacturer.

iii. Discarded when empty or upon the manufacturers labeled expiration date.

2. Oral liquid medications:

   a. May be used until the manufacturer's expiration date on the product.

   b. If contaminated or contents spill onto the outside of the container obscuring the label, the product must be returned to pharmacy for relabeling or discarded.

   c. Suspension medications, prepared by adding a diluent to a powder, must be discarded after the recommended expiration date for reconstituted suspension described on the product.

3. External Medication:

   a. May be used until the manufacturer's expiration date on the product.

~~If contents spill onto the outside of the container obscuring the label,~~

   b. ~~the product must be discarded.~~If contents spill onto the outside of the container obscuring the label, the product must be returned to pharmacy for relabeling or discarded

4. Sterile Irrigation Solutions: The expiration date shall be assigned by the pharmacist as per standard references or standard pharmacist practice. ~~Refer to LHH expiration checklist~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 31-01 Wireless Refrigerator And Freezer Temperature Monitoring System~~None~~
LHH Pharmacy Policy and Procedure 02.01.06 Expiration Dating of Pharmaceuticals

Revised: 16/01/12(Year/Month/Day)
Original adoption: 05/11/01

SCABIES MANAGEMENT

POLICY:

1. Residents are to be screened for scabies infestation by the licensed nurse upon admission, preferably before being transferred into a bed.

2. A licensed nurse or physician will promptly assess any resident with a suspicious skin rash and / or pruritispruritus.

3. Whenever possible, the diagnosis of scabies should be confirmed by identifying the mite or mite eggs or fecal matter (scybala), however, a negative skin scraping does not preclude treatment in the presence of a suspicious rash since as few as 10-15 mites may be present.

4. The infection control staff are nurse is to be informed of suspicious or confirmed cases of scabies.

5. Special Contact Precautions are to be implemented for suspected or confirmed cases.

6. Scabies **outbreaks** shall be managed with a comprehensive, interdisciplinary approach that usually includes infection control, medicine, nursing, pharmacy, clinic / employee health, and environmental services. An outbreak suggests that transmission has been occurring for several weeks to months since the time from exposure to symptoms may be as long as 4-6 weeks (1-4 days if previous infestation has occurred).

    a. Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among residents, health care workers, visitors or volunteers during a 2 week period should be considered an outbreak.

PURPOSE:

To promptly identify, treat, eradicate, and report scabies infections to prevent transmission to other residents and personnel.

PROCEDURE:

1. Suspicious rashes shall be promptly assessed by the licensed nurse and physician and infection control shall be notified when scabies is being ruled out.

    a. The predominant symptom of scabies is pruritus and symptoms of scabies always includes a rash, however, the rash varies greatly and may appear as small lines, red, raised bumps (papules), pustules or blisters. Itching is usually

intense, especially at night, however itching may be absent in immunocompromised residents and persons with decreased sensation.

b. Scabies rashes are usually found between fingers, front of wrists, elbows, axilla, belt line, thighs, genitalia, female breast, abdomen, male genitals and the lower portion of the buttocks. In long term care facility residents, lesions may be more predominant on the areas of the skin having contact with moist sheets such as the back and buttocks.

Mode of Transmission

a.

2. When scabies is first suspected and continuing throughout diagnosis and treatment of confirmed scabies, the nursing staff is to observe skin **contact isolation precautions** (long sleeve gown and gloves and double bagging soiled linen) during resident care activities.

   a. This period of contact precautions includes 24 hours after initial and subsequent administration of a scabicide (per CDPH guidelines).

3. **Transmission** of scabies occurs primarily through prolonged skin-to-skin contact with a person who has conventional scabies, therefore standard precautions usually protects staff from exposure. .

   b. Scabies can also be transmitted by indirect contact with an infested person's clothing, bedding, or towels (fomites), particularly with crusted (Norwegian) scabies where thousands to millions of mites may be present.

   c. The first time a person gets scabies they will usually have no symptoms during the first 2-6 weeks they are infested; however they can still spread scabies during this time.

   d. Shorter periods of skin-to-skin contact with person who have crusted of scabies form (i.e. "Norwegian" scabies) may also result in transmission.

a. Wearing an infested person's clothing (fomites) such as sweaters, coats, or scarves.

> NOTE: Body Substance Precautions require the routine use of barriers (gloves/gowns) by personnel to avoid skin-to-skin contact with non-intact skin and rashes of patients. Therefore, personnel at LHH should routinely avoid exposure to scabies by adhering to the principles of Body Substance Precautions as the standard of care (refer to policy C 02 for additional details).

2. Description of Scabies Infestation

~~a. Symptoms of scabies always includes rash, however, the rash varies greatly – may appear as small lines, red, raised bumps (papules), pustules or blisters.~~

~~b. Rash usually found between fingers, front of wrists, elbows, axilla, belt line, thighs, genitalia, female breast, abdomen, male genitals and the lower portion of the buttocks. In long term care facility residents, lesions may be more predominant on the areas of the skin having contact with moist sheets such as the back and buttocks.~~

~~3. Definition of Scabies Exposure: Anyone who had skin-to-skin contact with infested individual. Significant exposure includes:~~

~~a. Family members~~

~~b. Sexual contacts~~

~~c. Normal physical contact such as hugging, bathing or bed making.~~

~~d. Activities such as performing physical assessments, bathing and changing a~~

~~e. resident's soiled linen are inductive to transmission because physical contact~~

~~f. Often prolonged.~~

~~4.When~~4. When scabies is suspected, the licensed ~~registered~~ nurse is to notify the physician and encourage him/her to obtain ~~do~~ a skin scraping as soon as possible ~~immediately~~ to ~~obtain a~~ confirm~~ed~~ the diagnosis, preferably through a dermatology referral since experience is essential to getting an adequate skin scraping and correctly identifying mites.

a. It is reasonable ~~appropriate~~ for the physician or other trained clinician on any shift to do the skin scraping if the ~~before possible~~ referral to dermatology ~~skin~~ clinic cannot occur promptly.
~~and before ordering application of a scabicide~~

~~a.~~b. For skin scraping, request a skin scraping kit from CSR and refer to Appendix B Skin Scraping Guideline as needed.

5. Once scabies infestation is diagnosed, either by suspicious rash, skin scraping or both, notify neighborhood staff, including EVS, in order to coordinate interventions.

a. One case of non-crusted scabies with a negative skin scraping may not need interventions beyond treatment of the one case and their environment.

b. One or more cases of crusted scabies or non-crusted scabies confirmed by skin scraping requires contact investigation and treatment of close contacts and additional prophylactic treatment for crusted scabies.

~~a.~~c. If more than one case of scabies is diagnosed within 2 weeks of another case among residents, staff, or visitors, then coordination among interdisciplinary department heads/ designees is warranted. (i.e. Includes representation from infection control, medicine, nursing, pharmacy, clinic/ employee health, EVS and will expand based upon contact investigation line list (see Appendix D)

6. **Mass treatment and treatment of non-residents** shall be coordinated through the interdisciplinary team assembled for this purpose including infection control, medicine, pharmacy, nursing, EVS, clinic/ employee health and other representatives needed, depending on the extent of the outbreak, and includes treatment of symptomatic persons and prophylactic treatment of exposed persons when more than one case has been identified (outbreak). Treated individuals may return to LHH 8-14 hours after treatment.

   b. Mass treatment shall follow mass prophylaxis processes. (See 70-03 Emergency Response, Appendix H Hazard Specific Plans, 2 Emergency Responder Dispensing Plan.)

7. A **physicians order** is required for treatment; consult current CDC guidelines for appropriate medications (currently Permethrin initially and repeated 1 week later for non-crusted scabies with the addition of oral Ivermectin for crusted scabies).

   a. For mass treatment, pre-printed orders may be provided by pharmacy.

   b. Follow package instructions for prescribed treatment(s) unless otherwise ordered.

   c. After incontinent care, reapply a thin layer of scabicide during treatment period.

8. **Bedding, clothing, and towels** used by infested persons or their household, sexual, and close contracts anytime during the 3 days before treatment should be decontaminated by machine washing in hot water and drying using the hot dryer cycle (or dry clean).

   a. **Items that cannot be laundered** can be treated by storing in a closed plastic bag for several days to a week. (Scabies mites generally do not survive more than 2-3 days away from human skin).

   b. Change ALL bed linens before returning resident to bed after the scabicide has been showered off 8-14 hours after application AND

implement the bed stripping and bedside cleaning nursing procedure (D9 3.0).

9. **Environmental cleaning** of rooms used by residents with scabies includes thorough cleaning and vacuuming by personnel wearing long sleeved gown and gloves.

    ~~c.~~a. In addition to bed stripping and bedside cleaning, nursing staff shall replace disposable personal care items such as oral hygiene equipment, water pitcher, urinal/ bedpan and personal disposable BP cuff.

    ~~d.~~b. Usual disinfection is adequate for non-disposable items, such as wheelchairs, glasses, Disinfect wheelchair according to usual wheelchair cleaning procedure.

    ~~e.~~c. EVS shall clean the room and bathroom, including chairs and toilet seats, according to usual procedures and remove and replace the cubicle curtains in the room and bathroom.

    d. Request for vacuuming of upholstered surfaces that may have come in contact with infested or exposed resident(s). Use dedicated vacuum; empty bag and wipe down vacuum when finished vacuuming.

~~8.~~

10. **Contact Investigation** begins promptly upon identification of one case verified by skin scraping or more than one case identified by either skin scraping or suspicious rash. (One case with a negative skin scraping may not need interventions beyond treatment of the one case.)

    a. The Infection Control Department staff initiates the contact investigation during usual business hours utilizing the CDPH Prevention and Control of Scabies in Long-Term Care Facilities publication as a guide.

    b. The Nursing Operations manager will initiate the contact investigation list when infection control staff are off duty.

    c. Refer to Appendix D, Contact Investigation Guideline for details.

11. **Outbreak Reporting** is done by the Infection Control staff to Quality Management, SFDPH Communicable Disease Control and Prevention, and CDPH according to the following parameters:

    a. Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among residents, health care workers, visitors or volunteers during a 2 week period should be considered an outbreak for reporting purposes.

12. **Post Treatment Assessment** is conducted by the Infection Control staff to determine if treatment was effective. The intensity of the rash and pruritus should gradually resolve over a 7-14 day period. If signs and symptoms persist or intensify or if new lesions are identified within 7-14 days, treatment failure should be considered.

13. **Documentation** includes:

    a. Medical record: Record procedure, medications used, description of resident's skin and reaction of the resident. Record and describe any allergic symptoms or persistent pruritus.

    b. Complete an Unusual Occurrence Record: Include skin description and medication prescribed. If this is a newly admitted resident, include the name of facility and the unit the resident came from.

ATTACHMENT:

Appendix A: Scabies Quick Reference Guide
Appendix B: Scabies Skin Scraping Guideline
Appendix C: Contact Investigation Guideline
Appendix D: Contact Investigation Recommended Forms
- D-1 Index Case History and Contact Identification
- D-2 Contact Identification – Asymptomatic Residents
- D-3 Contact Identification List – Symptomatic Healthcare Workers, Volunteers, Visitors
- D-4 Contact Identification List – Asymptomatic Healthcare Workers, Volunteers, Visitors

REFERENCE:

LHHPP 70-03 Emergency Response, Appendix H: Hazard-Specific Plans, (2) Emergency Responder Dispensing Plan
LHHPP 72-01 Infection Control Manual, A9 Contact/ Exposure Investigation
~~LHH Nursing Policies and Procedures Manual, 2002~~
CDC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings available at http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html
CDC Scabies Resources for Health Professionals – Institutional Settings at http://www.cdc.gov/parasistes/scabies/health_professionals/control.html
~~Scabies Diagnosis accessed 7/31/15 @ http://www.cdc.gov/parasites/scabies/diagnosis.html~~
~~A Resource for Infection Control in Long Term Care Facilities, Utah Department of Health and Bureau of Epidemiology, August 1997.~~
California Department of Public Health Division of Communicable Disease Control, Management of Scabies Outbreaks in California Health Care Facilities, March 2008
~~DHS, Management of scabies outbreaks in California health care facilitis, March 2008.~~

Revised: 16/01/12 (Year, Month, Day)
Original adoption: Est. 05/11/01

Appendix A: Scabies Quick Reference Guide

SCABIES QUICK REFERENCE GUIDE		
Identification	Licensed Nurse are to screen for scabies infestation: ▪ upon admission, preferably before transferring resident into bed ▪ when suspicious rashes and/ or pruritus are present	Severe itching and a papular (pimple-like) rash and tiny burrows may be seen between fingers, at wrist, elbow, axilla, genitals, nipple, waist, buttocks, and shoulder blades but may be absent or atypical in immunocompromised and those with decreased sensation. Commonly on skin in contact with moist surfaces such as sheets (check back and buttocks).
Isolation	Contact Precautions for **suspected** or confirmed cases.	Use gown, gloves for contact prior to treatment, for applying scabicide and for washing off scabicide after 8-14 hours.
Diagnosis	Licensed Nurse is to notify physician promptly.	Skin scraping may be done by a clinician who is trained and experienced with the procedure. A negative skin scraping does not necessarily rule out scabies infestation since there may be as few as 10-15 mites.
Treatment of Resident	RN, LVN, C.N.A., PCA may apply scabicide ordered by the physician.	Apply per package instructions, unless ordered otherwise, from the neck down to the soles of the feet. Shower off (preferably) 8-14 hours after treatment. Reapplication in 7 days is usual, particularly for crusted scabies and whenever itching does not improve after 7-14 days or new burrows or papules continue to appear. Simultaneously treat resident's close contacts or persons with close contact with bedding, clothing, and towels.
Treatment of Environment	Double bag linens and personal items in plastic. Contact EVS for regular cleaning and vacuuming.	Washable items can be laundered in hot soapy water and dried thoroughly on high. Place non-washable items in plastic and seal for at least 3 days. EVS must follow contact precautions (gown, gloves) for usual daily cleaning. Vacuuming is recommended. Insecticides and fumigants are not recommended.
Treatment of Staff	Standard precautions are generally adequate to prevent resident to staff transmission.	Single cases of non-crusted scabies not confirmed by skin scraping may not require treatment beyond the source case. LHH will provide treatment products when treatment or prophylaxis is necessary. Staff may return 8-12 hours after appropriate treatment with a scabicide agent.

Appendix B: Scabies Skin Scraping Guideline

SCABIES SKIN SCRAPING GUIDELINES		
#	Step	Guideline
1.	Who may perform skin scraping	Skin scrapings should always be performed by a clinician who is trained and experienced in performing the procedure. During regular business hours it is preferable for the physician to refer the resident to dermatology clinic.
2.	Supplies	Obtain a scabies skin scraping kit from CSR containing: 3 slides with cover slips Alcohol wipes (10) Surgical blades (3 ea. #11 and #15 scalpels) Magnifying glass Mineral Oil dropper bottle Applicator Sticks (4) Washable felt tip marker Band Aids (10) Sterile exam gloves, sizes 7 & 8 Gowns (2) Sharps Container Good light source Microscope (Transport slides in kit tray to Clinic room with microscope: rm. P1339.)
3.	Select scraping sites	Clean hands and observe contact precautions with skin though out the procedure using gloves and gown. Use magnifying glass under good light to examine skin for new burrows or papules. (Mite will not be found in excoriated, scabbed or infected papules but unscratched newer papules may be found among them or at new sites.) Place 2-3 drops of mineral oil on each slide Cleanse the selected scraping site with alcohol. A burrow ink test can be done to identify the burrow by covering cleansed area with ink from a non-permanent felt tip pen, then wiping the ink off with an alcohol wipe to view the burrow where the ink that has seeped into it.
4.	Perform the skin scraping	Place a few drops of mineral oil on the selected scraping site. Hold the blade at a 90 degree angle and gently scrape the lesion while pulling the skin taut with the other hand. Increase the pressure slightly while scraping. A small amount of blood may be visible, however, there should be no frank bleeding. Transfer the scraping to a slide. Obtain at least 4-6 scrapings per resident. More than one scraping can be placed on a slide. When done, cover with a cover slip. Discard blade into sharps disposal. Discard other supplies then discard gown and gloves into the same plastic trash bag, secure closed and place in the trash. Wash hands. Don new gown and gloves to transport slides to clinic in clean kit container.
5.	Microscopic examination	Examine the entire slide preparation under lower power magnification for evidence of mites, eggs or fecal pellets. Non-physician clinicians should contact a physician to confirm a diagnosis. Discard slides into sharps disposal container. Discard container that held the slides, gown and gloves into plastic bag then place in red biohazard container (double bag).
6.	Document	Document findings in residents chart.

APPENDIX C: Contact Investigation Guideline

APPENDIX B: CONTACT INVESTIGATION The Infection Control Nurse initiates a contact identification list and conducts a contact investigation. The Operations Nurse Manager initiates the contact identification list when the Infection Control Nurse is off duty.		
1.	Initiate a contact ~~indentification~~identification list, beginning with the affected unit, and Notify Department Heads upon identification of: • one case verified by skin scraping or • More than one case identified by either skin scraping or suspicious rash. • One case with a negative skin scraping may **not** need interventions beyond treatment of the one case since standard precautions are usually adequate to prevent the spread of common (non-crusted) scabies. .	Use the Appendix D, CDPH forms. Begin with roommates, residents, and nursing staff who have had contact with the source resident(s). Notify Department Heads to assist with identifying contacts from their respective departments. Include nursing, medicine, EVS, ATs, social services and other departments identified with potential contact with the infested resident. Include any students, volunteers or departments with staff who have had contact with the source resident(s) within the last 45 days. Determine the daily routines of the case for the previous 45 days and identify exposed residents located on the same nursing unit or other nursing units. Include resident contacts who have been discharged and resident contacts from other units. Determine if the source case was transferred to another health care facility for treatment, such as dialysis, within the past 45 days. Notify the other facility's infection control practitioner. Notify visitors (spouse, family members, or friends) who may have visited the case within the past month. The nurse manager/charge nurse is to inform resident's visitors and refer them to their own physician, unless an outbreak has been declared. Determine if the contacts are symptomatic or asymptomatic. Determine if household contacts or the sexual partner of the symptomatic health care worker, volunteer, or visitor has signs of scabies infestation. Determine if there are symptomatic health care workers, residents, volunteers, or visitors on other nursing units.

		If an initial evaluation indicates no unusual complaints or pruritus or changes in the condition of the skin, treatment may not be indicated. However, a follow-up evaluation should be done at least every other day for four (4) weeks.
1.	Refer symptomatic contacts to their personal physician unless an outbreak has been declared.	Symptomatic persons may return to LHH 8-12 hours after treatment.
2.	Mass distribution of scabicides and / or antiparasitics when an outbreak has been declared. Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among residents, health care workers, visitors or volunteers during a 2 week period should be considered an outbreak for reporting purposes.	An outbreak is declared by the medical director in ~~coordinatin~~coordination with infection control. Mass distribution of scabicides (usually Permethrin) and / or antiparasitics (i.e. ivermectin) is coordinated with pharmacy and others consistent with mass prophylaxis guidelines. Pharmacy assists in obtaining or providing orders, product, product tracking, and distribution in coordination with the LHH clinic, medicine and affected departments according to the contact investigation logs. Under mass prophylaxis guidelines, assistance from non-LHH DPH personnel is appropriate depending upon needs and the determination of the medical director and / or incident commander. For Mass Prophy details, refer to LHHPP 70-03 Emergency Response, Appendix H: Hazard Specific Plans, 2. Emergency Responder Dispensing Plan (http://in-sfghweb01/lhh/policies/070/70-03Appendix/index.htm)
3.	Workers compensation claims	Workers compensation claims shall be completed by managers for staff with confirmed scabies diagnosis following a LHH source case.
4.	Infection Control Reporting	Reporting includes unusual occurrence for single cases or outbreaks and reporting of outbreaks to CDPH and local SFDPH Communicable Disease Control and Prevention Unit.
5.	Infection Control Reporting and Follow up assessment	Infection control staff / committee shall follow the CDPH guidelines for Prevention and Control of Scabies in California Long-Term Care Facilities and CDPH Management of Scabies Outbreaks in California Health Care Facilities (March 2008 or more current if updated) in conjunction with current CDC recommendations available on-line to determine the effectiveness of treatment and guide next step interventions in the case of treatment failure.

APPENDIX D-1: INDEX CASE HISTORY AND CONTACT IDENTIFICATION

RESIDENT CONTACT: (Name) ______________________________

Unit	Room #	Resident Name	Date of Symptoms Onset	Results of Skin Scraping (+, -, not done)	Date Ist Treatment	Symptoms Resolved (Y/N;	Date of 2nd Treatment	Symptoms Resolved (Y/N; Date)	Results of follow up Skin Scraping (+, -, not done)

Comments: Resident has ~ Typical; ~ Atypical; ~ Crusted Scabies Recommended treatment: ~Permethrin (Elimite); 5% ~ Alternative (identify) ______________________________

CONTACT IDENTIFICATION -- SYMPTOMATIC RESIDENTS

Unit	Roo m #	Name	Date of Symptoms Onset	Results of Skin Scraping (+, -, not done)	Date of Treatment	Date of 2nd Treatment	Symptoms Resolved (Y/N;	Comments

APPENDIX D-2: CONTACT IDENTIFICATION – ASYMTOMATIC RESIDENTS

SOURCE									
Unit	Room #	Resident Name	Date of Symptoms Onset	Results of skin scraping (+, -, not done)	Date Ist treatment	Symptoms Resolved (Y/N; Date)	Date 2nd treatment	Symptoms Resolved (Y/N; Date)	Results of follow up skin scraping (+, -, not done)
			See Appendix A1						
Comments:									

CONTACT IDENTIFICATION -- ASYMPTOMATIC RESIDENTS

Unit	Room #	Name	Results of Skin Scraping (+, -, not done)	Date of 1st Treatment	Date of 2nd Treatment	Symptoms Resolved (Y/N; Date)	Comments

-APPENDIX D-3 CONTACT IDENTIFICATION LIST – SYMPTOMATIC Healthcare Workers, Volunteers, Visitors

RESIDENT CONTACT: (Name) ______________________________

SYMPTOMATIC CONTACTS

Name	HCW: CLASS C Cla	VOL	VIS	Date of Symptoms Onset	Results of Skin Scraping (+) (-) not done	Date of Treatment	Symptoms Resolved (Y/N;Date)	Date Family Treated	Comments

APPENDIX D-4 CONTACT IDENTIFICATION LIST – ASYMPTOMATIC Healthcare Workers, Volunteers, Visitors

RESIDENT CONTACT (NAME) ______________________						
ASYMPTOMATIC CONTACTS						
Name	**HCW: CLASSIFICATION c**	**VOL**	**VIS**	**Date of Treatment**	**Treatment Recommended (Y/N)**	**Comments**

14. If the physician is unable to do a skin scraping, the infection control registered nurse may do so and save the specimen in the laboratory.

15. If the infection control registered nurse's skin scraping confirms presence of mites or eggs, he/she is to notify the physician and nursing area supervisor immediately.

16. If the diagnosis is confirmed on a weekend, the PM shift or night shift, the specific resident is to be treated immediately according to the physician's orders.

17. Obtain a confirmed diagnosis of scabies by an MD through either skin scraping or clinical diagnosis.

18. When scabies is first suspected and continuing throughout diagnosis and treatment of confirmed scabies, the nursing staff is to observe skin contact isolation precautions (long sleeve gown and gloves and double bagging soiled linen) during resident care activities.

19. If scabies infestation is confirmed through clinical diagnosis (absence of mites or eggs through microscopic identification), the resident suspected with scabies may receive scabicide treatment/MD order. The entire ward may not require treatment.

20. When one positive scabies case is confirmed (presence of mites or eggs through microscopic identification), the resident will be treated, and in addition, it may require treatment for the entire ward or community. When scabies is suspected and treated at the time of admission, the entire ward may not require treatment.

21. Treatment is given to all residents on a ward at the same time. The following departments are to be notified by the area nursing supervisor to supply the needs of the wards that are going to have a mass scabicide treatment:

    Central Supply Room
    Housekeeping/Linen Department
    Pharmacy

22. The area nursing supervisor/infection control nurse will notify department heads to request that they inform their employees who have close contact with the resident. Departments may include Nursing, Medical, Dental, Radiology, Laboratory, Respiratory Therapy, Activities, Volunteers, Pastoral Care, Rehabilitation Services, EKG, students and other appropriate departments. The infection control nurse should develop a contact investigation list. Initially, the contact identification list should be limited to the nursing unit where the confirmed

case resides. See attached contact identification list of residents or staff. See Attachment C.

23.

24. Include the nursing unit, room number, name, date of onset symptoms, results of skin scrapings, date of initial treatment, date of follow-up treatment, results of treatment (e.g. Condition resolved or not resolved) and the date and results of repeat skin scrapings, if performed.

25.

26. Identify roommates of the case. Include roommates who have been discharged, moved to other nursing units or to another health care facility within the previous month.

27.

28. Determine the daily routines of the case for the previous 45 days and identify exposed residents located on the same nursing unit or other nursing units.

29.

30. Determine if the case was transferred to another health care facility for treatment, such as dialysis, within the past 45 days. Notify the other facility's infection control practitioner.

31.

32. Notify visitors (spouse, family members, or friends) who may have visited the case within the past month. The nurse manager/charge nurse is to inform resident's visitors and refer to them to their own physician unless an outbreak has been declared.

33.

34. Identify health care workers and volunteers who have had direct physical contact with the case. The infection control nurse will request staffing attendance from nursing office within the past month. List the names of employees per shift and give this to the NM or NS in charge of that shift so that they can advise employees to gown and gloves and/or obtain the appropriate scabicide treatment. Determine if these contacts are symptomatic or asymptomatic. People in the same household of the employee who had contact with scabies are to be referred to their own physician unless the medical director and infection control committee declares an outbreak.

35.

36. Determine if household contacts or the sexual partner of the symptomatic health care worker, volunteer, or visitor has signs of scabies infestation.

37.

38. Determine if there are symptomatic health care workers, residents, volunteers, or visitors on other nursing units. If an initial evaluation indicates no unusual complaints or pruritus or changes in the condition of the skin, treatment may not be indicated. However, a follow-up evaluation should be done at least every other day for four (4) weeks.

39.

40. After developing a contact identification list, the infection control practitioner should determine who should receive treatment and the treatment schedules to be followed. Resident, health care worker, visitor, and volunteer contacts should

be treated as soon as possible, preferably within the first 24-48 hour treatment period. Volunteers and students who do their clinical practice at LHH will be treated at LHH.

41.

42. A physician's order is required for the scabicide treatment. The order must specify the name of the medication, the number of treatments, how frequently it is to be applied, and the length of time the scabicide is left on the skin. If clarification is necessary, the ward nurse or medical clinic nurse is to confer with the physician at the time the order is written.

Treatment of Health Care Worker, Visitor, and Volunteer Contacts

Symptomatic health care workers, volunteers, and visitors and their contacts should be treated during the same treatment period as the symptomatic residents are treated. Health care workers should be allowed to return to work following a single application (8-12 hours) of permethrin. Follow-up treatments are not necessary unless re-exposure occurs or symptoms persist. The following information may be useful in determining who needs to be treated.

43. Contact with a symptomatic case has not been substantiated. No treatment is required. However, approval of one (1) application of scabicide should be granted if requested.

44. Contact with a symptomatic case is minimal such as delivering dietary trays or newspapers and books. Treatment is not necessary. However, approval for one (1) application of scabicide should be granted of requested.

45. Contact with a symptomatic case is substantial such as bed making, physical assessment, or turning resident. Asymptomatic and symptomatic persons should be treated with one (1) application of permethrin. Family members, roommates, and sexual partners of symptomatic cases should also be treated at the same time. Retreatment may be necessary if symptoms persist following the first treatment.

Symptomatic health care workers, volunteers, and visitors should follow the instructions for washing clothes and decontaminating the home environment outlined in the prevention of transmission section of this guideline.

46. When all residents on the ward are to receive treatment, the nurse manager/charge nurse will be provided with typed standard order sheets for the appropriate scabicide which are to be placed in the resident's chart for the physician's signature.

47. Place symptomatic resident(s) on isolation precautions in their bedside or assigned rooms. Restrict resident(s) to their room(s) for the duration of the first treatment (8-12 hours). Following bathing to remove the first application of

scabicide, discontinue isolation precautions. Isolation precautions are not necessary for prophylactic treatments (e.g. follow-up treatments or treatment of asymptomatic contacts).

48. In an epidemic outbreak, as declared by the Medical Director and/or the Infection Control Committee:

49. Those employees who had contact with the positive scabies case within 45 days prior to when the confirmed diagnosis was made, will receive the appropriate scabicide treatment.

50. It will be decided by the Infection Control Committee and the Medical Director when the scabies treatment will be dispensed to resident's family and friends and employee's family in the same household and students who do their clinical practice here.

51. Prescriptions are needed for each medicine dispensed to an employee. The amount of scabicide is to be written on each prescription by AND/NS of each shift and placed in the nursing office mailbox of the infection control nurse, who will then forward it to the Pharmacy.

52. Pharmacy will dispense the appropriate scabicide to employees, resident's family and friends, and volunteers who can obtain this through the nursing office.

J. **REPORTING OUTBREAKS**

Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among residents, health care workers, visitors or volunteers during a 2 week period should be considered an outbreak for reporting purposes. A separate set of recommendations, "Scabies outbreaks in California health care faciliies," March 2008, is available. The infection control nurse should report outbreaks to quality management and to the local health officer and to the California Department of Health Services.

Procedure:

A. Equipment

1. Obtain from Pharmacy:
   a. Medication, as prescribed for each resident receiving treatment
      i) Elimite cream
      ii) Eurax lotion or cream
      iii) Other scabicides, Mectizan

2. Obtain from Central Supply:
   a. Skin scraping tray (infection control nurse)
   b. For staff

i) Isolation gowns (long sleeve gowns)
ii) Non sterile vinyl gloves
iii) Chux to cover lift slings
iv) Large plastic liner bags for resident's property

c. For residents
i) Toothbrush and holders
ii) Soap dishes
iii) Water pitchers and liners
iv) New ID bands and name inserts
v) Plastic draw sheets

3. Obtain from Ward Supply:
a. Nail clippers
b. Disposable gloves

4. Obtain from Linen Room:
a. Linens for beds
b. Resident gowns
c. Pillows
d. Red bags

B. Preparation for resident:
1. Explain procedure to resident.
2. Screen resident for privacy.

C. Skin Scraping Procedure:

Skin scrapings should always be performed by a clinician who is trained to perform the procedure. Nurse practitioners and physician's assistants can also perform the procedure if they have been trained by a clinician.

1. Obtain the following equipment
- gloves and gowns
- slides and cover slips
- magnifying lens and light source such as goose neck lamp
- alcohol impregnated wipes
- felt tip pen (green or blue)
- Clear nail polish (if applicable)
- Mineral oil and dropper
- Applicator sticks
- Surgical blade
- Sharps container

- ~~Compound microscope (if available)~~

~~2. Procedure~~

~~a. Observe resident's skin with a magnifying lens and look for lesions suggestive of scabies infestations. The shoulders, back, abdomen, hands, wrists, elbows, buttocks, axillae, knees, thighs and breasts are common sites for burrows.~~

~~b. Using a hand-held magnifying lens and a strong light, look for new burrows or papules. If the burrow or papule is very fresh, a tiny speck (mite) may be visualized at either end of the burrow or in the papule. The mite will not be found in excoriated, scabbed or infected skin lesions. Preserved, unscratched papules may sometimes be found in a grouping of scratched papules.~~

~~c. Visualize burrows using the "burrow ink test" described in the text.~~

~~d. Select an unexcoriated burrow or papule.~~

~~e. Prepare slides by dipping an applicator stick into mineral oil and transferring 2-3 drops to the center of several clean slides.~~

~~f. Dip a hypodermic needle into the mineral oil and transfer a drop of oil to the lesion selected for scraping and spread the oil evenly over the intended scraping site.~~

~~g. Hold the skin taut with one hand and hold the hypodermic needle at about a 5-10 degree angle with the other hand. If a surgical blade is used, hold blade at a 90-degree angle.~~

~~h. Apply light pressure and scrape the lesion making several movements across the lesion. Increase the pressure slightly while scraping. A small amount of blood may be visible, however, there should be no frank bleeding.~~

~~i. Transfer skin scrapings to prepared slide and place a cover slip over the scrapings.~~

~~j. Obtain at least 4-6 scrapings per resident.~~

~~k. Examine the entire slide preparation under lower power magnification for evidence of mites, eggs or fecal pellets. If a compound microscope is not available at the facility, secure the cover slips with clear nail polish and transport slides to a clinical laboratory, physician's office or local public health laboratory.~~

~~If more than one resident has signs or symptoms of infestations, repeat the procedure using clean equipment on at least one other symptomatic resident. If~~

health care workers are symptomatic, skin scrapings should be performed on at least one (1) symptomatic health care worker.

D. Care of resident receiving scabicide medications

1. Nursing Staff to wear cloth or disposable long sleeve gowns when applying the scabicide and for all direct resident contacts during the defined treatment period. Gowns may be reused by the same health care worker during an entire shift, and then discarded.

2. Wear gloves when applying the scabicide and for all direct resident contacts during the defined treatment period. The cuff of the glove should cover the wrist of the gown. Gloves should be discarded immediately following the completion of any task involving skin contact during the defined treatment period.

3. Instruct visitors to wear a long sleeve gown and gloves until after the scabicide has been washed off.

4. Wash hands, wrists and lower arms following removal of gowns and gloves.

5. Bathe or shower the resident(s) prior to applying scabicide if the resident has not been bathed within the previous 24 hours. Wash hair and clip and clean resident's finger and toe nails.

6. Apply the medication.

   a. When Elimite or Kwell is prescribed, schedule the first application at a reasonable time on the PM shift, bearing in mind that the day shift will give a cleansing tub bath 8-12 hours later to remove the medication.

7. Nursing alert

   a. Observe carefully for signs of allergic reaction, such as skin rash, especially with sulfur preparations. Many residents exhibit persistent pruritus (itching) after treatment, which is not necessarily a treatment failure. Report reactions immediately to a physician. Protect yourself by handwashing and gloving as indicated in the procedure.

      i) Other Scabicides

         (a) Follow the physician's order and consult Pharmacy, the PDR, or Drug Facts and Comparisons for additional information for other prescribed scabicides.

8. After medication is applied:

a. Dress resident in clean gown or pajamas.

b. Return resident to his/her bed.

c. If resident is incontinent, reapply a thick layer of the prescribed medication each time the resident has received incontinent care.

9. Cleaning the tub:

a. After bathing the resident, scrub porcelain enamel white bath tub with housewide approved disinfectant.

b. Let tub dry for 15 minutes before using again.

E. Care of Property and Environment:

1. The resident's bed linen

a. Wash personal clothes worn by the resident during the preceding week in hot water and laundry detergent. Dry in a hot dryer.

b. Place all non-washable personal clothes such as shoes, coats, jackets, and scarves worn by the resident during the preceding week in a plastic bag to have items dry cleaned or place them into a hot dryer for 20 min. If this is not possible, seal the plastic bag for 5-7 days.

c. Change all bed linen including blankets and spreads following the initial application of scabicide. Remove all used towels, wash cloths, and bed clothes worn by the resident. Place these items in a plastic bag and send to the laundry for processing. It is not necessary to change the linens at the time the scabicide medication is applied. The next day, the day shift is to strip all the bed linen, clean the unit, and red bag personal property.

d. Change bed linens, towels, and clothing after the scabicide has been washed off.

e. Place linen in a linen bag. Fill bags only ¾ full to prevent them from splitting. Close the bags securely and dispose in the linen chute.

f. Wash transfer-sling in hot water cycle and dry. Use washed clean slings after scabicide treatment.

2. The Resident's Unit

a. Wash the unit with disinfectant and water, according to bed-stripping procedure after scabicide has been washed off (pay special attention to seams on mattress and pillow). Disinfect the bedside table and stand inside and outside, the bed, including the footboard, water cushion, trapeze, signal cord and rubber sheet. Disinfect multiple use equipment such as walking belts and blood pressure cuffs.

b. The Nurse Manager/charge nurse is to notify Housekeeping to remove and send cubicle curtains to laundry for processing.

c. Scabies mites do not usually survive away from the host (the person) for more than three days, but to eliminate their survival on clothing, seal the resident's s personal articles (shoes, clothing, toiletries, etc.) in a plastic bag for fourteen days. Label and store in ward locker room.

d. Disinfect the resident's watch, ring, eyeglasses and hearing aide with soap and water.

e. If resident has a urinary drainage bag or colostomy bag, replace it.

f. Sterilize the resident's emesis basin, toothbrush holder, and oral hygiene cup.

g. Clean the comb and brush using germicide according to the comb and brush Nursing procedure on page D9 4.0.

h. Dispense a new water pitcher, cup and toothbrush.

i. Wash with disinfectant and dry the resident's wheelchair, bedside unit furniture, commode, and transport gurney (if used).

j. The nurse manager/charge nurse is to notify Housekeeping to wash all ward furniture used by resident, including toilet.

k. Discard any topical creams, ointments or lotions used by symptomatic cases.

l. Disinfect upholstered furniture and cover with plastic for 14 days.

F.

Dermatologist recommend applying 1% hydrocortisone cream or triamcinolone cream (0.1%-0.025%) to the most intense areas of pruritus and a lubricating agent or emollient to the areas of the skin less affected. Steroid creams, however, should

not be applied until after the scabicide has been removed. Antihistamines may also be effective in relieving some of the symptoms.

G. **Documentation**

Medical record: Record procedure, medications used, description of resident's skin and reaction of the resident. Record and describe any allergic symptoms or persistent pruritis.

Make out Unusual Occurrence Record: Include skin description and medication prescribed. If this is a newly admitted resident, include the name of facility and the unit the resident came from.

Treatment of Symptomatic Cases

Effective treatment of typical scabies requires the application of a safe and effective scabicide (agent that kills the mite). Until recently, the standard treatment was 1% Lindane (Kwell). However, the scabies mite has become increasingly resistant to this product and it is no longer recommended for the treatment of scabies. Additionally, neurotoxicity has been reported in some patients following a single application.

Permethrin (Elimite) 5% Cream

The current recommended treatment for scabies is %5 permethrin cream, a synthetic pyrethroid. When applied to the skin as directed, it is approximately 90% effective after one application. (4) Two applications may be required and is often recommended to assure complete eradication. The cream has a low rate of reported side effects, which consist of burning, stinging or itching immediately following application.

Animal studies have shown no adverse effects to reproductive function or to the fetus. However, studies have not been done on pregnant women. Therefore, permethrin should be used during pregnancy only if thee is a clear indication for treatment. Breast-feeding should be discontinued during the treatment period. Permethrin is safe for children 2 months of age or older.

Application of Permethrin

To avoid treatment failures, permethrin must only be applied by health care workers who have been specifically trained in application techniques.

1. Treat case(s) and their contacts during a defined 24-48 hour treatment period. Symptomatic cases should be treated during the first 24-hour treatment period. Asymptomatic contacts can be treated during the second 24-hour treatment period.

2. Massage permethrin into the skin covering the entire body from the hairline to the soles of the feet. Include the forehead, ears, and neck. Avoid the mucous membranes of the eyes, nose and mouth. Flush the eyes with copious amounts of water if permethrin exposure occurs.

3. Reapply permethrin to areas of the body, which have become moist following application.

4. Bathe or shower and shampoo the resident within 8-12 hours following treatment to remove the scabicide.

5. If a second application of permethrin is necessary, it can be applied immediately following the removal of the first application or up to 3-7 days later. Bathe or shower and shampoo the resident 8-12 hours following the second application.

6. If symptoms of scabies persist, a third and fourth application of permethrin may be required.

Crotamiton (Eurax) 10%

Crotamiton lotion is only about 50% effective in the treatment of scabies. The safety and effectiveness in children has not been established. Allergic and irritant dermatitis may occur in some persons. The product should not be used on acutely inflamed or open skin lesions. There are no human or animal data on the safety of this product during pregnancy.

Ivermectin (Mectizan)

Ivermectin is an antiparasitic agent that has been used to treat onchocerciasis (river blindness) in Africa. A single oral dose of 200 ug/kg (12 mg) used in conjunction with karyolytic agents has been effective in the treatment of crusted scabies. For an update on ivermectin, see "Control of Scabies Outbreak in California Health Care Facilities," February, 1999.

Alternative Treatments for Crusted Scabies (See Appendix C)

Treatment of Health Care Worker, Visitor and Volunteer Contacts

Symptomatic health care workers, volunteers and visitors and their contacts should be treated during the same treatment period as the symptomatic residents are treated. Health care workers should be allowed to return to work following a single application (8-12 hours) of permethrin. Follow-up treatments are not necessary unless re-exposure occurs or symptoms persist. The following information may be useful in determining who needs to be treated.

Contact with a symptomatic case has not been substantiated. No treatment is required. However, approval of one (1) application of scabicide should be granted if requested.

2. Contact with a symptomatic case is minimal such as delivering dietary trays or newspapers and books. Treatment is not necessary. However, approval for one (1) application of scabicide should be granted if requested.

Contact with a symptomatic case is substantial such as bed making, physical assessment or turning resident. Asymptomatic and symptomatic persons should be treated with one (1) application of permethrin. Family members, roommates, and sexual partners of symptomatic cases should also be treated at the same time. Retreatment may be necessary if symptoms persist following the first treatment.

Symptomatic health care workers, volunteers and visitors should follow the instructions for washing clothes and decontaminating the home environment outlined in the prevention of transmission section of this guideline.

ATTACHMENT:
[List Attachments in alphabetical order]

[Appendix A: Type Name of Attachment]
[Appendix B: Type Name of Attachment]
or
[Type None]

REFERENCE:

[List references in numeric order when the reference relates to a policy number, otherwise list in alphabetical order.]

[Type in here, or type None]

Most recent review: xx/xx/xx (Year/Month/Day)
Revised: xx/xx/xx
Original adoption: xx/xx/xx

~~ANTIBIOTIC~~ ANTIMICROBIAL USE GUIDELINES

POLICY:

An integrated approach for the control of emerging resistance will be conducted ~~Thorough~~ through ongoing collaboration and cooperation of the Infection Control Committee, the Infection Control staff, the Pharmacy and Therapeutics Committee, the Pharmacy, and the Laguna Honda Hospital and Rehabilitation Center (LHH) physicians ~~of M7A, LHH has an integrated approach for the control of emerging resistance.~~

PURPOSE:

~~Laguna Honda Hospital has an antibiotic~~To control and monitor~~ing~~ antimicrobial use ~~program in place~~ to minimize selection pressure associated with overuse of broad-spectrum antibiotics and to reduce the likelihood for development and transmission of multidrug resistant bacteria.

PROCEDURE:

1. An approved antibiotic formulary has been developed and is in use at LHH. Please refer to the UCSF/SFGH/LHH Lexicomp® e-Formulary for details.

   To access website click on this hyperlink:
   http://www.crlonline.com/lco/action/home/switch

2. Treatment guidelines ~~(e.g., Handbook of Antimicrobial Therapy)~~ for empirical therapy and treatment of common bacterial infections ~~of in-residents~~ have been developed by UCSF/SFGH/VASF and are in use at LHH. Please refer to the Joint UCSF/SFGH/VASF Infectious Diseases Management Program (IDMP) website.

   To access website click on this hyperlink:
   http://idmp.ucsf.edu/guidelines-empiric-antimicrobial-therapy

~~1.~~3. Emergence of antibiotic resistance in LHH is monitored prospectively through ongoing Infection Control surveillance and adoption of antimicrobial management policies and procedures described in LHHPP 25-07.

~~2. For further details see Policy A 05.~~

ATTACHMENT:
None.

REFERENCE:
Website links listed in Procedure #1 and #2.
LHHPP 25-07 Antimicrobial Management in Acute Medicine at Laguna Honda Hospital.
~~None~~

Revised: 16/01/12 (Year/Month/Day)
Original adoption: 05/11/01 (Year/Month/Day)

EVALUATION OF COMMUNICABLE ILLNESS IN HEALTH CARE WORKERS ~~PERSONNEL~~

POLICY:

~~1.~~ Health Care Workers (HCW's)~~Personnel~~ with communicable or potentially communicable disease shall be evaluated for work fitness to prevent the transmission of disease to residents and other health care workers. ~~personnel.~~

~~2.~~ ~~Definintion~~**Definition:** The term "health care worker (HCWs) are defined as persons, paid or unpaid, working in health care settings who have direct contact with residents or who work in resident care areas. ~~personnel" is defined as all employees, volunteers, students, and medical staff working within the facility on a continuing basis, unless otherwise stated.~~

PURPOSE:

To minimize the risk for disease transmission. ~~at Laguna Honda Hospital (LHH), a policy is in place to evaluate personnel for communicable diseases.~~

PROCEDURE:

1. Staff shall not come to work with potentially contagious illnesses including influenza or any illness with a fever (until afebrile for 24 hours without the use of medication), uncontrolled diarrhea, vomiting, persistent cough or sputum production consistent with tuberculosis, contagious or suspicious rash, skin lesions or weeping dermatitis that is not easily kept covered with secretions contained, untreated conjunctivitis, or symptoms of hepatitis such as jaundice.

   a. Refer to Appendix A and B for disease-specific guidance including transmission risk, immunization requirements, definitions for infection and exposure, work restrictions and reportable illnesses.

2. Any illness that may be job-related shall be reported to the supervisor for reporting to SFDPH Occupational Safety and Health at 101 Grove, in accordance with the LHH Injury and Illness Prevention Program (LHHPP 73-01).

3. A health care worker with a communicable or potentially communicable disease must avoid resident contact and report illness to infection control and SFDPH Occupational Health Services at SFGH.

~~1.~~4. ~~LHH~~ SFDPH Occupational Health Services ~~Employee Health Service~~ has the authority to evaluate health care workers who have been exposed to or have

symptoms of a communicable disease, and implement appropriate work restrictions, exclusions, and referral to TB clinic. ~~or exclusions.~~

~~2. A health care worker with a communicable or potentially communicable disease must avoid resident contact and report illness to the Employee Health Service and the Infection Control Nurse.~~

~~3. Personnel who have had an exposure to a person with a communicable disease are required to report to the LHH Employee Health Service.~~

~~4. Personnel with the following symptoms should be evaluated for work fitness by LHH Employee Health:~~

~~a. Fever and chills~~

~~b. Persistent cough or sputum production consistent with tuberculosis.~~

~~c. Rash or vesicles~~

~~d. Skin lesions or weeping dermatitis~~

~~e. Draining wounds~~

~~f. Diarrhea or vomiting~~

~~g. Jaundice~~

~~h. Sore throat with fever~~

~~i. Red eyes / conjunctivae~~

~~5.~~ SFDPH Occupational Health Services is required to report ~~The LHH Employee Health Service reports~~ all exposures and suspected/confirmed cases of communicable disease in personnel to Infection Prevention and Control Officer (IPCO) or designee. ~~Infection Control.~~

~~6.~~5.

~~7.~~6. The Laguna Honda IPCO or designee is responsible ~~The Infection Control staff maintains responsibility~~ for initiating a Contact Investigations as described in section A9 of the Infection Control Manual. ~~if deemed necessary.~~

~~8. Disease-specific details such as transmission risk, immunization requirements, definitions for infection and exposure, and work restrictions are contained in~~

ATTACHMENT:

Attachment A: Table of Illnesses/Infections and Related Work Restrictions None

Attachment B: Sub-table of Diarrheal, Vomiting, and Acute GI Illness with known Enteric Organisms

REFERENCE:

LHHPP 72-05 Employee Influenza Vaccination(s) Policy and Use of Surgical Masks When Vaccination(s) is Declined
CDC (1998). Guideline for Infection Control in Health Care Personnel.
SFGH (2015) Occupational Health Table of Illnesses/Infections and Related Work Restrictions and Sub-table of Diarrheal, Vomiting, and Acute GI Illness with known Enteric Organisms

Most recent review: xx/xx/xx (Year/Month/Day)
Revised: 16/01/12xx/xx/xx(Year/Month/Day)
Original adoption: 05/11/01 xx/xx/xx

Attachment A: Table of Illnesses/Infections and Related Work Restrictions

(Adapted ~~with permission~~ from SFGH Infection Control / Occupational Health)

~~Key:~~ *if highly suspicious or confirmed in accordance with SFDPH criteria;
Yes (1): Reportable within 1 day
Yes (7): Reportable within 7 days
PEP – Post Exposure Prophylaxis
Contact the Infection Prevention and Control Officer for information if links fail.

Illness/Infection	Transmission	Incubation; Communicability	Reportable*	PEP	HCW Restrictions
Acute febrile illness	Varied; depending on the causative agent	N/A	No	No	May not work until fever resolved without the use of fever-reducing medications. If fever has persisted for 5 days or more, a physician evaluation should be obtained and clearance submitted to Occupational Health Services prior to returning to work.
Respiratory Illnesses					
Cold/Cough	Direct Contact or Inhalation of Respiratory Droplets; Indirect hand contact	Varied	No	No	Exposure: None Active Disease: Personnel with cold symptoms may work but are instructed to comply with certain measures to prevent transmission (cover mouth and nose with tissue; wash hands immediately after use of tissue; frequently clean surfaces that may have been contaminated with respiratory secretions); wear a mask and change mask after cough or sneeze.
Upper Respiratory Infection (unspecified)	Direct Contact or Inhalation of Respiratory Droplets; Indirect hand contact	Varied	No	No	Exposure: None Active Disease: Personnel with Upper Respiratory Infections may work but are instructed to comply with certain measures to prevent transmission (cover mouth and

					nose with tissue; wash hands immediately after use of tissue; frequently clean surfaces that may have been contaminated with respiratory secretions); wear a mask and change mask after cough or sneeze.
Illness/Infection	**Transmission**	**Incubation; Communicability**	**Reportable***	**PEP**	**HCW Restrictions**
Influenza (link to Influenza policy/ATD) http://in-sfghweb01/lhh/policies/072/72-05.pdf http://in-sfghweb01/lhh/policies/073/73-07.pdf	Droplet	1 to 4 days; 1-2 days before onset to 4-5 days after onset	No. (Unless outbreak)	Possible. (Consult with Employee Health)	Exposure: Varied Disease: RTW 24 hours after resolution of fever and respiratory symptoms or 7 days after onset
Pertussis http://in-sfghweb01/lhh/policies/073/73-07.pdf	Droplet	4-21 days; ~21 days during the catarrhal period (runny nose, sneezing, low-grade fever, symptoms of the common cold) and 1st 2 weeks after cough onset)	Yes (1)	Yes	Exposed personnel should contact OHS and monitor themselves for symptoms. If cough develops, personnel may not return to work until completion of 5 days of appropriate antibiotic therapy.
	Definition of Exposure: To be considered exposed to pertussis, personnel must have had direct contact with the respiratory secretions of a probable pertussis case without the use of personal protective barriers.				
Measles (Rubeola)	Airborne	10-12 days; 5 days prior to 7 days after onset of rash	Yes (1)	Yes	Exposed: Any unprotected HCW shall be removed from work on day 5 thru day 21 after exposure. Active Disease: Any HCW diagnosed with measles shall be relieved from work immediately and for a period of 7 days

					following the appearance of the rash or for the duration of acute illness, whichever is longer.
	Definition of Exposure: To be considered exposed to measles, a person must be susceptible to measles (nonimmune or immunocompromised) and have shared airspace within the same room for 5 minutes or more with a confirmed or probable case of measles without the use of appropriate PPE (N-95 mask).				

Illness/Infection	Transmission	Incubation; Communicability	Reportable*	PEP	HCW Restrictions
Mumps	Droplet or direct contact with saliva	14-18 days (range 14-25 days) 2 days before to 9 days after onset of parotid swelling	Yes (7)	No	**Exposure:** If susceptible, personnel may not work from 12 days (after the first exposure date) to 26 days (after the last exposure date). **Disease:** Personnel diagnosed with mumps are removed from work until 9 days after onset of parotitis.
	Definition of Exposure: To be considered exposed to mumps, a person must be susceptible to mumps (nonimmune or **immunocompromised**) and have prolonged (>1 hour) of close contact (w/in) 3 feet with a probable case.				
Rubella (German measles)	Droplet	12 to 23 days; 7 days before to 5-7 days after onset of rash	Yes (7)	No	**Exposure:** Any person considered exposed will be excluded from work from 7 days after first exposure through 21 days after last exposure. **Disease:** Personnel who meet the clinical criteria for rubella should be excluded until 7 days after appearance of rash.
	Definition of Exposure: To be considered exposed to rubella, a person must be susceptible to rubella, and have maintained close **contact** (w/in 3 feet) with a probable case for 5 minutes or more OR have had any direct contact with an infant diagnosed with congenital rubella syndrome.				
RSV	Droplet & Contact with respiratory secretions	2-8 days; 3-8 days (infants upto 4 weeks)	No	No	Personnel may work but should comply with certain measures to prevent transmission (cover mouth and nose with

					tissue; wash hands immediately after use of tissue; frequently clean surfaces that may have been contaminated with respiratory secretions).
Group A Streptococcus	Contact with infected secretions or body fluids; Droplet	1-5 days;	No	No	Personnel with GAS infection may return to work 24 hours after treatment with appropriate antimicrobial therapy started and symptom improvement.
Illness/Infection	**Transmission**	**Incubation; Communicability**	**Reportable***	**PEP**	**HCW Restrictions**
Tuberculosis http://in-sfghweb01/lhh/policies/073/73-07.pdf http://in-sfghweb01/lhh/InfectionControl/IC_ManualFrames.htm	Airborne	2 to 12 weeks;	Yes (1)	No	**Exposed:** Any personnel exposed may work without restriction, but need to follow-up with OHS. **Active Disease**: Any employee with signs of active pulmonary TB should immediately refer to OHS. May not return to work until cleared by OHS in consult with TB control.
Varicella http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po35.pdf?12/4/20158:31:43 AM	Airborne (primary varicella & disseminated shingles) Direct contact with infected lesions	10- 21 days (varicella); 1-2 days before onset of rash until all lesions are crusted over	No	Yes. (High risk individuals after consultation with their PCP or in absence of PCP, ID/IC medical director)	**Primary varicella/Disseminated zoster:** May not work until all lesions are dry and crusted over **Zoster/shingles:** 1)face/forearms- may not work until lesions are dry and crusted 2) chest, back, abdomen, or legs- may works if lesions are covered **Exposed HCW:** May not work from days 10 to 21 post exposure
	Definition of exposure: To be considered exposed to varicella, HCW must be susceptible (non-immune) to varicella, share airspace within the same room for >1 hour with a probable case of chicken pox or disseminated shingles, OR have face-to-				

	face contact for ≥ 5 minutes with a probable case of chicken pox or disseminated shingles, OR have any direct skin-to-skin contact with a probable case of chicken pox or shingle, either form.				
Meningococcal Disease http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po21.pdf?12/4/20158:31:43 AM	Droplet	3 to 4 days (Range 2 to 10 days);	Yes (1)	Possible.	Exposed: None. Active Disease: Personnel with meningococcal disease will be excluded from work for at least 24 hours after start of effective therapy and until they feel well enough to return to work.
	Definition of exposure: Direct contact with an infectious person's secretions without wearing personal protective equipment. **Examples** of direct contact include: face-to-face exposure during a coughing attack; physical exam of nose/throat; oral care; suctioning the patient; intubation; bronchoscopy; performing CPR w/o use of protective barriers.				
Illness/Infection	**Transmission**	**Incubation; Communicability**	**Reportable***	**PEP**	**HCW Restrictions**
Contact					
Conjunctivitis	Contact (Direct or Indirect)	Varies based on organism.	No	N/A	Personnel with conjunctivitis may not have patient contact until symptoms of eye drainage have resolved.
Enterovirus (Coxsackie virus/ hand, foot and mouth disease)	Direct or Indirect contact with infected respiratory secretions and infected stool; Droplet	3-5 days; Shortly before onset of acute symptoms to several weeks	No	No	Personnel diagnosed with or describing symptoms of enteroviral disease may not work with newborns, infants, or young children until symptoms resolve. As long as secretions are contained, including fluid from blisters, staff may return to work with adults.
Herpes Simplex	Contact between exposed/broken skin and lesions or virus-containing secretions	2 to 7 days; 7 to 12 days	No	Not routine.	Genital: Personnel may work w/o restriction but should practice good hand hygiene Facial: Personnel should mask for direct patient care while lesions are draining Hands/fingers: Personnel should be excluded from direct patient care until lesions are dry and crusted

Draining wounds & skin lesions a) Hands, arm, face b) Areas covered by clothing	Possible contact between exposed/broken skin and lesions or secretions	Variable	No	No	a) Personnel may not work until lesions have healed. b) May work as long as areas are well covered by dressing that remains dry throughout work shift.
Lice (Pediculosis) http://in-sfghweb01/lhh/InfectionControl/IC_ManualFrames.htm	Contact with infected person or object used on the hair/clothing	N/A	No	No	Personnel with lice should be removed from work until 12 hours after treatment with a hospital-approved treatment.
Illness/Infection	**Transmission**	**Incubation; Communicability**	**Reportable***	**PEP**	**HCW Restrictions**
Scabies http://in-sfghweb01/lhh/InfectionControl/IC_ManualFrames.htm	Skin to skin contact (crusted scabies requires shorter contact time)	2 to 6 weeks (may be shorter for "crusted" scabies)	No	Possible.	Personnel with scabies must remain out of work until 8 to 12 hours after appropriate treatment with scabicide agent.
Rabies	Bite from infected animal; Contact w/ infected tissue, excretions, secretions	Incubation 3-8 weeks	Yes	Yes	Determined on a case-by-case basis.
	Definition of exposure: Personnel have been bitten by a patient or animal with rabies, or if provided care to a person with rabies and have scratches, abrasions, open wounds or mucous membrane splashed with saliva or other body fluid				

Appendix B: Diarrhea, Vomiting, Acute GI Illnesses
(Adapted with permission from SFGH Infection Control / Occupational Health)

Illness/Infection	Transmission	Incubation; Communicability	Reportable*	PEP	HCW Restrictions
Diarrhea, Vomiting, or Acute GI Illness (General)	Contact Fecal-oral	Varied	No	No	Personnel may not work if they have acute diarrhea or acute GI illness. RTW when symptoms resolve. If diarrhea lasts 3 or more days, contact OHS for evaluation prior to returning to work.
	If stool specimen positive for enteric organism (source organism known), *click here*. http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po11.pdf?12/4/20158:31:43 AM				
Hepatitis A (5.16)	Contact Fecal-oral	15-50 Days 2 weeks before to 1 week after symptom onset.	Yes (1)	Yes	Restricted from patient care areas and food handling until 7 days after the onset of jaundice
	Exposure Definition: Considered exposed if contact with excrements of patient diagnosed with Hepatitis A or if close contact or food preparer diagnosed with Hepatitis A				
Bloodborne pathogens (Link to Bloodborne Pathogen policy: http://in-sfghweb01/lhh/policies/073/73-06-01132015.pdf)					
Hepatitis B	Bloodborne	6 weeks to 6 months; 1-2 months before and after onset of symptoms; chronic carriers	Yes (7)	Yes	None
Hepatitis C	Bloodborne	2 weeks to 6 months;	Yes (7)	No	None
HIV	Bloodborne	N/A	Yes (7)	Yes	None

ACTIVITY THERAPY

POLICY:

1. Every member of the Activity Therapy department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Activity Therapy services staff:

   a. LHHPP 76-03 Animal Control

   b. LHHPP 26-05 Neighborhood Specialty Meal Program

   c. LHHPP 28-01 Community Outing Program

   d. LHHPP 28-02 Farm and Therapeutic Gardens

   e. LHHPP 28-03 Aquatic Services

   f. LHHPP 28-04 Pool Servicing and Aquatic Area General Maintenance

   g. Activity Therapy Policy P5.0 Animal Assisted Therapy

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

BARBER AND BEAUTICIANS

POLICY:

The beauticians shall follow the standards set by their respective professional board requirements,~~;~~ the LHH Nursing Department, and the Infection Control Committee.

PROCEDURE:

1. Beauticians are to wear appropriate washable uniform or smock and to keep their person and clothing clean when attending resp~~ati~~idents.

2. Employees are to follow the Hand Hygiene policy C4 before and after attending each ~~patient~~resident. Employees can wear a disposable apron as desired and can wear gloves while working with the residents, however, the gloves must be removed, hands cleaned, ~~-~~and gloves changed between residents.

3. Cut hair is to be removed from floors frequently, using dust-less method.

4. Freshly laundered towels or individual sanitary neck strips are to be used for each resident~~patient~~.

5. Clean towels are to be stored in a closed or covered area, used for only one ~~patient~~resident and deposited in a closed receptacle until laundered.

6. Closed sanitary receptacles are to be used for waste materials.

7. All supplies or instruments which come in direct contact with ~~patients~~ residents are to be disinfected using the Oster Spray and Barbi~~s~~cide. Alcohol solution is used to disinfect scissors and razors.

8. Beauticians are to thoroughly wash with soap and water then disinfect all instruments in fresh Barbicide solution immediately after use on each ~~patient~~resident.

9. Containers for disinfection are to be labeled, have covers, and be of sufficient size to accommodate all instruments.

10. All instruments disinfected in a chemical solution are to be rinsed with water and dried prior to ~~patient~~ resident use.

11. Hair and debris are to be removed from exterior clipper surfaces with a brush used only for that purpose prior to disinfection of the blades~~ with a brush used only for that purpose~~. The blades shall be removed, thoroughly washed and then disinfected.

12. All liquids, creams and other preparations are to be kept in properly labeled, clean, and closed containers. When only a portion of a preparation is used on a ~~patient~~resident, it is to be removed using a tongue blade in such a way as not to contaminin ~~in~~ ate the remaining portion.

13. Residents must not be served in the beauty salon when neck or scalp contains draining lesions, except on the order of ~~the patient's~~~~resident's~~the resident's physician.

14. If a resident is suspected to have a lice infestation, care is to be withheld and the Nurse Manager or charge nurse notified immediately.

ATTACHMENT:
None.

REFERENCE:
~~None~~
LHHPP 72-01 Infection Control Manual, C2 Standard Precautions
LHHPP 72-01 Infection Control Manual, C4, Hand Hygiene

~~Most recent review: 2145/11/24 xx/xx/xx (Year/Month/Day)~~
Revised: 16~~5~~/~~1~~01/12~~24~~ ~~xx/xx/xx~~(Year/Month/Day)
Original adoption: 05/11/01 ~~xx/xx/xx~~

CENTRAL SUPPLY/MATERIALS MANAGEMENT

POLICY:

Laguna Honda Hospital has a policy in place for the cleaning and disinfection of resident care equipment according to standards of practice.

PURPOSE:

Contamination of resident equipment is prevented by routine cleaning and disinfection.

PROCEDURE:

1. Central Supply processes, issues and controls medical supplies and equipment, both reusable and disposable sterile and non-sterile, to departments and units of Laguna Honda Hospital. It shall be the primary center for decontamination and sterilization of reusable medical supplies and equipment.

2. Standard precautions will be practiced in procedures carried out in Central Supply.

3. Decontamination will be performed in the area designated as the soiled area.

4. Processing area is a clean area where supplies and equipment are managed after decontamination.

5. Sterilization is done in a designated area by the central supply staff.

6. Commercially prepared items without a specified expiration date and labeled by the manufacturer as “sterile until opened or damaged” shall be considered as sterile until opened or damaged. P~~Each p~~ackages ~~should~~are ~~be~~ inspected for damage before distribution~~use~~.

7. ~~Sterilization is done by the central supply staff in outpatient clinics, for more information please refer to outpatient clinic manual.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, G5 Cleaning and Disinfection Non-Critical Resident Care Equipment

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

CLINICAL LABORATORIES

POLICY:

1. Every member of the Clinical Laboratories department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Clinical Laboratories services staff:

   a. A1 - Clinical Laboratory

   b. A2 - Phlebotomy Procedure

   c. A3 - Identification of Patient and Collection of Blood Specimen

   d. A4 – Blood Culture Procedure

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

DENTAL SERVICES

POLICY:

Since all residents infected with transmissible agents may not be identified, standard infection control precautions must be used routinely in caring for all dental residents.

PURPOSE:

To prevent the transmission of infectious agents between staff and residents and between residents by the proper use of handwashing and protective barriers and by the proper cleansing and disposal of used or contaminated equipment and surfaces.

PROCEDURE:

1. All procedures should be done in a way to minimize formation of droplets, spatters or aerosols.

2. Gloves must be worn for contact with mucous membranes, blood, or saliva. If gloves are punctured during a procedure, they must be removed, hands must be washed, and a new pair of gloves put on.

3. Between residents, gloves must be removed and hands and forearms must be washed before putting on another pair of gloves and examining the next resident. Soap and water provide adequate hand cleaning except for surgical procedures, when an antimicrobial surgical handscrub should be used.

4. When splattering of blood or body fluid is likely, masks and protective eyewear must be worn.

5. A lab coat or disposable gown must be worn over clothing and changed daily and when visibly soiled. Short sleeved attire is preferred. Clothing or lab coats which are soiled can be washed with hot, soapy water.

6. All surfaces that may be exposed to blood or saliva during procedures must be cleaned and disinfected between residents. Surfaces which may become contaminated with blood or saliva and which are difficult to disinfect must be covered with impervious material (aluminum foil, plastic wrap, or impervious paper). Gloved employees must remove the impervious material after each resident and replace the material after gloves are removed.

7. All needles and other disposable sharp instruments must be placed in the red, puncture-resistant needle boxes. Needles must not be recapped, bent, or broken.

8. All instruments must be physically cleaned by a staff member wearing heavy rubber gloves before any disinfection procedures. Instruments that penetrate soft tissue or bone must be sterilized (steam or gas) after each use. Instruments that do not penetrate tissue or bone (e.g. amalgam condensers, plastic instruments and burs) should be sterilized after each use if possible; however, high level disinfection is adequate if sterilization is not feasible. High level disinfection with chemical agents should follow manufacturer's recommendations.

9. Work surfaces must be physically cleaned at the end of each work day, then disinfected with a chemical germicide.

10. Materials used in the mouth (impression materials, appliances, etc.) must be thoroughly cleaned and disinfected before being handled, adjusted, or sent to a dental laboratory. These materials must also be cleaned and disinfected before being placed back in the resident's mouth after return from a dental laboratory.

11. If handpieces can be sterilized, this should be done. If this is not possible, the handpieces should be flushed, thoroughly scrubbed with a brush and detergent (e.g. 1-2-2) and then wiped with alcohol. This should be done between each use.

12. Check valves should be present in water retraction valves. Water cooled handpieces should be run for 20-30 seconds after use on each resident and for several minutes at the beginning of each day.

13. All disposable material, other than sharp instruments, that becomes contaminated with blood or saliva must be discarded in a labeled infectious waste container. Liquid material can be carefully poured into a drain.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

EKG DEPARTMENT

POLICY:

~~Universal Blood and Body Substance Precautions (BSI)~~ Standard Precautions shall be used to prevent skin and mucous membrane exposure when contact with blood or body fluids of any resident is anticipated.

PURPOSE:

To establish a policy whereby EKG technicians can prevent the spread of infection to themselves, co-workers and residents by proper use of handwashing and personal protective wear and by the proper cleansing of reusable equipment.

PROCEDURE:

1. Hands shall ~~must~~ be cleaned ~~washed~~ between residents~~patients~~ and in accordance with the Hand Hygiene policy. ~~.~~

2. Gloves must be worn when hands may come in contact with blood and body fluids, mucous membranes or non-intact skin of any resident. Hands must be washed after gloves are removed.

3. Gloves must be worn by the EKG technician if the technician has broken skin, rash, or minor skin infection. If technician has a weeping skin lesion, no direct ~~patient~~ resident contact is allowed.

4. Gloves, gowns and protective face and eye wear must be used in a Code Blue and any other emergency situation when blood, body fluids, secretions or excretions may splatter on clothing.

5. All reusable equipment that comes in contact with patients is decontaminated by an approved procedure.

6. Cable points and straps are cleaned ~~with~~ using alcohol based wipes between patients. ~~warm water and Alva-Quat germicide solution~~

~~6.~~7. Disposable electrodes are used.

~~7.~~8. Isolation Rooms:

   a. Appropriate mask shall be worn.

   b. EKG machine and all cable wiring shall be cleaned ~~with~~ using alcohol based wipes ~~Alva-Quat Disinfectant and germicidal solution~~ after use in isolation rooms.

ATTACHMENT:
None.

REFERENCE:
~~None~~
LHHPP 72-01 Infection Control Manual, C2 Standard Precautions
LHHPP 72-01 Infection Control Manual, C4, Hand Hygiene

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

NUTRITION SERVICES

POLICY:

1. Every member of the Nutrition Services department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Nutrition Services staff:

   a. LHHPP 26-04 Resident Dining services

   b. LHHPP 26-05 Neighborhood Specialty Meal Program

   c. LHHPP 26-06 Meal Tray Service Galley Sanitation

   d. Nutrition Services Department Policies and Procedures related to: food procurement, food storage, safe food handling and preparation, meal service and food distribution, machine washing and sanitizing equipment, manual washing and sanitizing equipment, and cleaning of fixed food service equipment

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

ENVIRONMENTAL SERVICES

POLICY:

1. Every member of the Environmental Services department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Environmental services staff:

   a. Environmental Services Policies and Procedures

      i. IV Job Descriptions

      ii. XII Critical Areas Cleaning Procedure

      iii. XV. Pest Control and Animal Abatement

      iv. XVI Ice Machine and Refrigerator Cleaning

      v. XVII Transport, Delivery Time for Biohazard, Trash and Linen

      vi. XVIII Microfiber Damp Mopping Cleaning

      vii. XX Cubicle Curtains and Drape Cleaning

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

SAN FRANCISCO SHERIFF'S DEPARTMENT PERSONNEL COMMUNICABLE DISEASE MANAGEMENT POLICY

POLICY:

San Francisco Sheriff's Department (SFSD) personnel at Laguna Honda Hospital shall abide by the San Francisco Sheriff's Department Policy D-17, Communicable Disease Management Policy and the LHH Standard Precautions and Hand Hygiene Policies.

PURPOSE:

To assure that SFSD personnel at LHH comply with California Code of Regulations, Title 8, Section 5193; Title 15, Article 10, Section 1206.5; and Health and Safety Code Sections 121060 and 121070.

PROCEDURE:

1. At all times during the course of their duty, SFSD personnel at LHH shall comply with San Francisco Sheriff's Department Policy D-17, Communicable Disease Management Policy.

2. SFSD personnel at LHH shall should be especially aware of the potential threats created by body substances when performing law enforcement functions, such as restraining or taking into custody, a violent suspect.

3. SFSD personnel at LHH shallshould be especially aware of the need to properly decontaminate and disinfect equipment that has contacted contaminated body substances, before again using or placing that equipment into service.

ATTACHMENT:
None.

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

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

NURSING

POLICY:

1. Every member of the Nursing department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Nursing services staff:

    a. Nursing Policies and Procedures

        i. Section D – hygiene and Comfort

        ii. Section J – Medication and Intravenous Therapy

    b. Hospital-wide Policies and Procedures

        i. LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan

        ii. LHHPP 73-11 Medical Waste Management Program

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

PHARMACEUTICAL SERVICES

POLICY:

1. Every member of the Pharmaceutical Services department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Pharmaceutical services staff:

   a. Pharmacy Policies and Procedures, Quality Improvement

      i. 03.03.00 Infection Control and Sterile Product Handling

      ii. 07.01.00 Sterile Product Preparation, Handling and Disposal

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

REHABILITATION SERVICES

POLICY:

1. Standard precautions will be maintained by staff throughout this procedure.

2. Hand hygiene will be maintained by staff according to policy.

PURPOSE:

To maintain a clean environment and prevent the spread of infection in the rehabilitation department including physical therapy, occupational therapy, speech and hearing, and Wellness Center areas.

Responsibilities:

1. Occupational, Physical, and Speech Therapy Senior Therapists

   a. Assess resident care and safety within the department.

   b. Evaluate products for use with direct patient care.

   c. Ensure proper maintenance and cleaning of all equipment.

   d. Periodically review and update all procedures and equipment.

   e. Submit all policies and procedures that may present an infection hazard to the Infection Control Committee for review.

   f. Provide continuing education classes for the employees in the rehabilitation services department with documented attendance.

2. Staff Responsibilities

   a. To be aware of procedure and follow through on their use.

   b. To present possible problems to their respective department head.

   c. To follow the hand hygiene policy, including hand hygiene with soap and water or approved alcohol-based sanitizer before and after each treatment.

~~3. Infection Control Committee~~

   ~~a. Provide a resource person to help in establishing and updating Infection Control policies and procedures relating to the Rehabilitation Services department.~~

b. ~~Review and approve all policies and procedures relevant to Infection Control.~~

c. ~~Review data concerning infections and practices, in the Rehabilitation Services department to detect and deter hazardous practices.~~

PROCEDURE:

1. Residents

a. Isolation precautions

i. The nursing unit shall notify the Rehabilitation Services department when a resident requiring any rehabilitative service is placed on room or wound isolation.

ii. All categories of isolation practiced by the nursing staff must be used by the Rehabilitation Services staff.

iii. Most residents who are in private isolation rooms are there to rule in or rule out contagious infectious disease. These residents should receive activity or rehabilitative therapy within the isolation room or by arrangement after consultation with Infection Control professionals.

- For residents on wound precautions, if the wound can be adequately covered, the resident may attend therapy sessions.
- Residents with active tuberculosis, chickenpox, measles, rubella, disseminated herpes zoster, and infectious diarrhea shall not attend therapy sessions outside of their rooms since the risk of transmitting infection to others is possible.
- Residents can have therapy sessions in their room, following appropriate infection precautions as outlined on the sign posted outside the resident's room.
- The nurse manager or charge nurse shall determine if the resident can safely attend therapy. Consultation from the Infection Control Nurse is available and encouraged.

b. All mat tables, plinths, wheelchairs, wheelchair cushions, tables and other therapeutic materials such as walkers, canes, tilt tables and exercise machines will be cleaned with approved disinfectant wipes daily and after each treatment when the resident is in direct contact with such equipment, or resident's body substances or fluids have come into contact with the therapeutic equipment.

c. Linen on mats will be changed by staff after each resident's use.

d. Soiled linen shall be placed in impervious plastic bags and must be securely closed during transport.

e. Floor mats will be cleaned with approved disinfectant wipes daily and after use by an incontinent resident.

f. A cut, abrasion, rash, or minor infection on hands shall be covered with gloves or finger cot while working. Employees with draining skin lesions shall not provide resident care requiring direct resident contact, and may be referred to Occupational Health or the Infection Control Nurse.

g. All body substances and fluids are considered to be potentially infectious.

   i. Use gloves for anticipated exposure to mucous membranes and body substances from all residents.

   ii. Dispose of sharps carefully in puncture-resistant containers.

h. For potential or anticipated exposure to body substances or fluids, staff must wear gloves. Hands must be washed or sanitized before and after glove use.

i. Continuing education

   i. All employees in the Rehabilitation Services department should be instructed in proper isolation techniques.

   ii. Periodically, classes on Infection Control policies and procedures should be conducted in the Rehabilitation Services department. Attendance is documented.

2. Visitors

a. Visitors can be permitted in the rehabilitation areas for teaching and demonstration purposes.

3. Materials

a. Sterile products

   i. All instruments and materials must be packaged according to approved procedures.

   ii. Senior Therapists (OT, PT, and ST) must be certain that all requirements of cleaning, sterilizing, wrapping, packaging, and storage are met, and that all stored sterile supplies are routinely checked for wrapper integrity and expiration dates.

b. Disposable items

i. Must be properly stored and not reused.

ii. Must be discarded via proper procedure for type of material.

iii. Infectious waste will be disposed of in the red waste container in the biohazardous waste storage room.

4. Equipment

a. Senior Therapists (OT, PT, ST) are responsible for written policies on proper maintenance and cleaning of all equipment. A yearly routine preventive maintenance schedule for all equipment has been established.

b. Records of maintenance and cleaning will be kept.

5. Housekeeping - The Apartment

a. Kitchen counter tops shall be cleaned by a therapy aide daily and after each use of the kitchen utilizing the 3 bucket (wash, rinse, sanitize) method.

b. Oven is cleaned as needed.

c. Refrigerator is cleaned weekly.

6. Food Preparation, Handling and Storage

a. Most food used for food preparation training is obtained from Food Service.

b. When a resident requires training with specific items not available from Food Service (e.g., boxed food; cultural food choices, etc.) items are purchased from an approved or reputable supplier (supermarket).

7. STORAGE OF FOOD

a. Staple food is stored in dated, closed containers, in small amounts.

b. All perishable foods are date labeled and stored at proper temperatures and temperature records are kept:

i. Fruits, vegetables, dairy products, meats and poultry are stored at temperatures below 41° F

ii. Frozen foods are stored at temperatures below 0° F

iii. When food or liquid is given to a resident, any unused portion is to be discarded, unless it is to be consumed by the same resident within 1-2 days in which case, it will be labeled with the current date, resident's name, and refrigerated.

iv. Separate and color coded chopping boards are used for raw meats. These chopping boards shall be washed thoroughly using the 3 bucket method, followed by sterilization in the industrial dishwasher located in the Apartment.

v. Chopping boards used for raw meats shall not be used for other foods.

ATTACHMENT:
None.

REFERENCE:
LHHPP 26-05 Neighborhood Specialty Meal Program
~~LHHPP 72-01 Infection Control, A2 Infection Control Committee Functions~~
LHHPP 72-01 Infection Control, C4 Hand Hygiene

Revised: 14/01/29, 16/01/12 (Year, Month, Day)
Original adoption: 11/01/01

FACILITY SERVICES

POLICY:

1. Every member of the Facility Services department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Facility services staff:

   a. Facility Services Policies and Procedures

      i. DP-31 Body Substance Isolation Procedure

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

RADIOLOGY SERVICES

POLICY:

1. Every member of the Radiology Services department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Facility services staff:

   a. Radiology Policies and Procedures

      i. D2 Departmental Cleanliness Radiology Policies and Procedures

      ii. F2 Infection Control

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

RESPIRATORY THERAPY

POLICY:

1. Every member of the Respiratory Therapy department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Respiratory Therapy services staff:

   a. Respiratory Therapy Policies and Procedures

      i. A4 Body Substance Isolation

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

OUTPATIENT CLINIC

POLICY:

1. Every member of the Outpatient Clinic department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Outpatient Clinic services staff:

   a. Environmental Services Policies and Procedures

      i. XII Critical Areas Cleaning Procedure

   b. Outpatient Clinic Policies and Procedures, Section C. Equipment Cleaning:

      ii. C3 Cleaning of Medical Instruments Prior to Dininfection or Sterilization

      iii. C4 High Level Chemical Disnfection

      iv. C6 Steam Sterilization

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

VOLUNTEER DEPARTMENT

POLICY:

1. Every member of the Volunteer department plays an active role in preventing and controlling the spread of infection, and shall adhere to established infection control policies, procedures and standards.

2. Department managers are responsible for training their staff on department specific infection control procedures that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. The following policies and procedures address infection control practices related to the job functions of the Volunteer Department services staff:

   a. Volunteer Department Services Policies and Procedures

      i. A4.0 Infection Control

2. Staff shall be trained on applicable procedures prior to their work assignment, and at a minimum, receive an annual performance evaluation, from their supervisor.

3. Department Managers are responsible for reviewing the above procedures annually, revising them as necessary, and training staff on new or revised procedures.

ATTACHMENT:
None.

REFERENCE:
See Procedure 1.

Revised: 16/01/12 (Year/Month/Day)
Original adoption: Est. 05/11/01

STANDARD FOR REFRIGERATION EQUIPMENT~~ORS~~

POLICY:

Laguna Honda Hospital (LHH) shall establish and implement standardized policies and procedures to monitor the function and cleanliness of refrigeration equipment according to accepted standards of practice.~~has a policy in place to monitor refrigerators to ensure compliance with accepted standards of practice.~~

PURPOSE:

To provide adequate refrigeration of food and biological products ~~that will~~to prevent the growth of microorganisms and minimize the risk of disease transmission to residents and health care ~~personnel~~workers.

PROCEDURE:

~~1. Standards for the use of refrigerators in the Hospital include:~~
~~2.~~
~~3.~~1. There are separate refrigerators for each purpose:

   i. ~~Household~~ Nutrition/Nourishment – for storage of resident's ~~nourishment.~~food.

   ii. Biological – exclusively for drugs or specimens needing refrigeration.

   iii. Staff – for ~~employees' lunches.~~storage of food brought in by employees for staff consumption.

2. Refer to LHHPP File: 31-01 Wireless Refrigeration and Warming Temperature Monitoring System for monitoring of refrigeration equipment.

3. Refer to Nursing Policies and Procedures D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerators via ~~TempTrak~~wireless temperature monitoring system & Cleanliness of Refrigerators for maintaining cleanliness of refrigerators on the neighborhoods.

4. Refer to Environmental Services Policy and Procedures XVI Ice Machine & Refrigerator Cleaning for external refrigerator cleaning.

~~2.~~ Refer to Nutritional Services Policies and Procedures 1.143 Storeroom Content: Security, Safety, & Sanitation for cleaning and sanitation of the main kitchen refrigerators.
~~3.~~

4. ~~All refrigerators are provided with thermometers. Thermometers are to be kept in the refrigerator and freezer sections of the household, biological and staff refrigerators.~~
5.
6. ~~There is a schedule for routine monitoring of:~~
7.
8. ~~Refrigerator temperatures; and~~
9.
10. ~~Accuracy of thermometers.~~
11.
12. ~~Temperature Range:~~
13.
14. ~~The Biological refrigerator temperature should be between 26°F and 46°F and must be locked at all times.~~
15.
16. ~~The household and staff Refrigerator temperatures should be maintained between 35°F and 45°F.~~
17.
18. ~~The freezer temperature range should be between 10°F to 20°F.~~
19.
20. ~~Monitoring:~~
21.
22. ~~Documentation of temperature monitoring is required.~~
23.
24. ~~Maintenance~~
25.
26. ~~There shall be a schedule of regular preventive maintenance of all refrigerators, including air vents, gaskets, cooling coils, and fans.~~
27.
28. ~~Cleaning~~
29.
30. ~~Certified nursing assistants on the PM shift are assigned to turn off the controls to defrost manually defrosted refrigerators. CNA's on the AM shift are assigned to clean the refrigerators and remove outdated foods when shelf life has expired.~~
31.
32. ~~The 11:45-7:45 am staff is to clean the Biological and staff refrigerators on Monday, and the household refrigerators on Wednesday.~~
33.
34. ~~Resident Food refrigerators~~
35.
36. ~~All food in refrigerators should be stored in covered containers.~~
37.
38. ~~Staff food refrigerators are expected to be maintained in a clean and hygienic manner.~~

~~39.~~5.

ATTACHMENT:
None.

REFERENCE:
See procedures 2, 3, 4, and 5.
~~None.~~

Revised: 16/01/12 (Year, Month, Day)
Original adoption: Est. 05/11/01

CHEMICAL STERILIZATION STANDARDS

POLICY:

Chemical sterilization at LHH shall be performed by trained Central Supply Technicians according to industry standards.

PURPOSE:

To provide basic guidelines for chemical sterilization of devices that cannot undergo steam or ETO sterilization.
~~Chemical sterilization is a process for the sterilization of critical patient care devices (devices that enter sterile tissue or access the vascular system) that cannot undergo steam or ETO sterilization. Chemical sterilization is effective in destroying all microbial life including bacterial spores.~~

~~Statement of Policy:~~

~~SFGH has a policy for chemical sterilization to ensure it is performed by trained, qualified personnel according to accepted standards of practice.~~

PROCEDURE:

1. Prior to the sterilization process, all devices are to be thoroughly cleaned to remove organic material and reduce the bioburden (refer to infection control policy, "Cleaning of Reusable Instruments").

2. Fluid resistant gowns, gloves, face masks, and eye protection (PPE) must be worn during the cleaning and sterilization process.

3. Chemical Sterilants must be mixed, stored and used in accordance with the manufacturer's recommendations.

4. Chemical sterilants approved for use at SFGH / CHN are 2% glutaraldehyde and 35% peracetic acid.

5. 2% glutaraldehyde solutions are to be used according to the following standards of practice:
   - Once mixed, the solution can be used for a maximum of 14 days.
   - The concentration of the solution must be checked with a test strip daily, each morning prior to use. Tests and results must be documented in a log.
   - Solution is to be discarded at the end of the 14 day period or, when test strip indicates solution is not at desired concentration (refer to Environmental Health and Safety for proper disposal).
   - Devices must be immersed in the solution for a minimum of 10 hours.

6. 35% peracetic acid solutions are to be used according to the following standards of practice:
   - 35% peracetic acid solutions are used in conjunction with a peracetic acid sterilization machine.
   - Devices are placed in the sterilizer according to manufacturer's instruction and run through one cycle.
   - At the conclusion of the cycle, the monitoring tape is to be checked to ensure sterility parameters have been achieved.
   - Chemical monitoring is done with each load.

7. After removing devices from the solution, rinse devices thoroughly with sterile water.

8. If an item's sterility must be maintained, sterile gloves are to be used when removing and handling device after completion of the chemical sterilization process. Item must be placed in a transport tray.

ATTACHMENT:
None

REFERENCES:
LHH Outpatient Clinic Policies and Procedures
LHH CSR/ Materials Management Policies and Procedures
APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996
Association for the Advancement of Medical Instrumentation Standards, 1996
Association of Operating Room Nurses Standards, 1997

Revised: 16/01/12 (Month, Year, Day)
Original adoption: Est. 05/11/01

BLOOD SPILL CLEAN-UP

POLICY

All surfaces and areas contaminated with blood are cleaned promptly and appropriately to minimize the potential for exposure to bloodborne diseases.

PURPOSE

To minimize the potential for exposure to bloodborne diseases from blood spills.

PROCEDURE

1. Environmental Services is responsible for the clean up and disinfection of the spill.

   a. Clinicians may clean up spills of a few drops using environmental wipes when there is no broken glass or debris. Gloves and hand washing are necessary.

2. Use standard precautions during clean up and disinfection. Type of personal protective equipment will vary with the size of the spill and if broken glassware is involved.

   a. Blood spill kits are available from CSR and contain absorbent powder and PPE.

   ~~a.~~b. Gloves are to be worn.

   ~~b.~~c. Fluid resistant gowns, shoe covers, mask and eye protection may be worn if there is potential for contamination of clothing or splashing/splattering is likely.

   ~~c.~~d. Broken glassware will be cleaned up using mechanical devices (i.e., dust pan and brush, tongs, forceps, etc.).

3. Contain the spill and remove gross material with paper towels or other absorbent materials/crystals. Disinfection shall not be done until all gross material is removed.

4. Disinfect contaminated area with hospital approved detergent/disinfectant that is tuberculocidal, such as bleach solution.~~.~~ Apply disinfectant and allow to air dry.

5. ~~Spray bottles of hospital approved disinfectant solutions are located on all nursing units and other clinical areas where there is potential for blood exposure.~~

~~(Refer to the Bloodborne Pathogen Exposure Control Plan for information regarding details of exposures not identified in this policy.)~~

ATTACHMENT
None.

REFERENCE

~~Reference:~~

LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
LHH Environmental Services Policy and Procedure XI. Collection, Handling, Storage and Disposal of Bio-hazardous Waste
OSHA Bloodborne Pathogen Standard, ~~1991~~ 2015

Revised: 16/01/12 (Year, Month, Day)
Original adoption: Est. 05/11/01

CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE EQUIPMENT

POLICY:

Laguna Honda Hospital (LHH) staff is responsible for routine cleaning and disinfection of non-critical resident care equipment according to established facility procedures.

PURPOSE:

To minimize the risk of transmission of pathogens during use of non-critical resident care equipment.

DEFINITION:

Non-critical resident care equipment includes items that come in contact with intact skin but not mucous membranes. Intact skin is an effective barrier where~~;~~ sterility of the equipment is not critical.

Non-critical equipment includes ~~many familiar hospital~~ items such as a bed alarm, bladder scanner, blood pressure machine (Dynamap or Welch Allyn), blood pressure cuff (DURA-CUF), crash cart, doppler, ECG machine, feeding pump, glucometer, gurney, hypothermal machine, infusion pump, isolation cart, nebulizer machine, patient-controlled analgesia (PCA), pulse oximeter, stethoscopes, suction machine, tympanic thermometer, and wheelchairs.

~~stretchers, wheelchairs and commodes.~~

~~The category of non-critical equipment may also include more technical equipment such as infusion pumps, dopplers, pulse oximeters, bladder scanners, glucometers, blood pressure cuffs, and stethoscopes.~~

PROCEDURE:

1. A hospital-approved phenolic-based, sodium hypochlorite (bleach) based or quaternary ammonium-based ~~(quat)~~ compound hospital disinfectant, which also contains a detergent so it both cleans and disinfects shall be used for the purpose of cleaning and disinfecting non-critical resident care equipment. Hospital approved ready-to-use pre-saturated "wipes" are available and accessible for staff use throughout the facility (i.e. currently green top wipes). A bleach based disinfectant must be used for disinfection of equipment used by residents infected with Clostridium difficile.

~~2. Cleaning and disinfection of non-critical resident care equipment is a shared responsibility. It will be performed by Environmental Services porters, nursing staff, and all personnel involved in the care of the resident at the unit level.~~

~~3. Environmental Services personnel retain the overall function of cleaning the resident room, furnishings and the environment.~~

2. ~~Nursing~~Clinical ~~staff~~ care personnel ~~and other resident care personnel~~ shall~~will~~ have the responsibility of cleaning and disinfecting equipment that is used between residents.

~~moved from resident to resident. Items that become contaminated or appear visibly soiled, will also be cleaned by unit based personnel.~~
~~The touch surfaces of equipment that is used on a single resident should be cleaned daily by unit based personnel.~~

The following non-critical care equipment are dedicated for use by one resident for the duration of the prescribed treatment.

- crash cart
- doppler
- feeding pump
- hypothermal machine
- infusion pump
- isolation cart
- nebulizer machine
- PCA
- suction machine

These items are obtained from Central Supply when first ordered for the resident. Nursing staff is responsible for cleaning the equipment daily and as needed while in use by the one specific resident. At the conclusion of the prescribed treatment, the equipment is returned to Central Supply for cleaning and disinfection before issued to another resident or returned to the vendor.
~~Equipment obtained from Sterile Processing and Distribution (Central Supply) will be returned to that department for cleaning. This equipment will be used for a single resident.~~

~~4. Personnel from all diagnostic or therapeutic services will clean and disinfect equipment on a routine basis, between uses by different residents.~~

~~5. The Product Evaluation Committee, supervising the purchase of new equipment for the hospital, shall consider the methods for cleaning. They shall also ensure that this information is conveyed to the department using this equipment. Information on equipment or product cleaning shall be obtained from vendor representatives who demonstrate how to use new equipment.~~

ATTACHMENT:
None.

REFERENCE:

LHHPP 72-01 Infection Control Manual, E4 Central Supply / Materials Management
APIC Guideline for Selection and Use of Disinfectants, 1996
APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996.
The Association for the Advancement of Medical Instrumentation.

Revised: 11/2005, 12/05/22, 16/01/12 (Year/Month/Day)
Original adoption: 05/11/01

ANIMAL CONTROL

POLICY:

Animals at Laguna Honda Hospital and Rehabilitation Center (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. Please refer to the Activity Therapy Departmental Policy and Procedure P5 Animal Assisted Therapy

2. Volunteers wishing to bring their pets to the hospital in order to participate in the animal assisted therapy program will be directed to the San Francisco SPCA. After successful completion of the training and registration into the SPCA program, the two organizations can coordinate visits.

3. LHH staff may bring their pets to the hospital to be used as pet companions for residents. Therapeutic interaction between those animals and the residents of 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 to bring their pets to be used as pet companions for residents 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 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.

    c. The employee must provide current vaccination records to be kept on file with their supervisor.

4. All pets must be on leash at all times while on hospital grounds unless the pet 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.

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.

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.

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.

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.

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

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.

11. Those residents who desire to keep a pet animal on the premises must first obtain permission from their Resident Care Team. 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.

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

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 who will contact Environmental Services Department to arrange animal disposal.

14. Anyone finding an injured animal on hospital grounds shall attempt to locate the owner if appropriate or contact Animal Care and Control for pick up.

ATTACHMENT:
None.

REFERNCES:
LHHPP 28-02 The Farm and Therapeutic Garden
Activity Therapy Departmental Policy and Procedure
P5 Animal Assisted Therapy

Revised: 10/12/01, 15/09/08 (Year/Month/Day)
Original Adoption: 92/05/20

ENVIRONMENTAL SERVICES

POLICY:

Environmental Services Department (EVS) is responsible for providing housekeeping, laundry and linen, mail and messenger, and shuttle services.

PURPOSE:

1. To provide a clean and sanitary environment.

2. To ensure an adequate supply of clean linen is available at all times to residents and ~~Hospital~~ Laguna Honda Hospital (Laguna Honda) departments.

3. To provide ~~hospital~~ Laguna Honda and residents' mail services.

4. To provide shuttle services between the ~~Hospital~~ Laguna Honda and the Forest Hill Muni station.

PROCEDURE:

1. Housekeeping Services

a. Hours of Operation:

i. Housekeeping Services operates seven days per week during two of the three ~~Hospital~~ Laguna Honda shifts. Day shift hours are 7:00 a.m. - 3:30 p.m. Evening shift hours are 3:30 p.m. - 12:00 midnight. Full service is provided on the day shift and basic service on the evening shift.

b. Scope of Services:

i. Routine cleaning of environmental surfaces in ~~Hospital~~ Laguna Honda resident ~~wards~~neighborhoods, clinics, pharmacy, clean supply, restrooms, offices, corridors, lobbies, entrances, walkways, etc. Window washing and floor care including mopping, stripping and refinishing.

ii. Collecting soiled linen for processing by laundry vendor.

iii. Storing and distributing furniture and equipment as scheduled or requested.

iv. Exchanging cubicle curtains and drapes as scheduled or requested.

v. Coordinating the pest control and animal/pigeon abatement program.

vi. Collecting and removing infectious waste and non-infectious waste from all areas of the ~~Hospital~~Laguna Honda. Coordinating the recycling program.

viii. Transporting equipment and supplies between buildings.

ix. Providing routine and special event general labor support.

x. Environmental Services maintains and periodically reviews and revises its EVS PP Manual, which contains detailed procedures.

c. Requests

i. Call 4-4624 for routine requests

ii. Submit project requests by memo or the appropriate form well in advance of the date the work is to occur.

2. Laundry and Linen Services

a. Hours of Operation:

i. Seven days per week on two shifts. Day shift hours are 7:00 a.m. - 3:30 p.m. Evening shift hours are 3:00 p.m. - 11:30 p.m. Delivery service is provided on the PM shift, basic service on the day shift.

b. Scope of Services:

i. Routine laundering and processing of departments' linen.

ii. Delivery of clean linen to units and user departments to maintain established par.

iii. Transporting soiled linen to and from collection by laundry vendor.

iv. Laundering and processing specialty items such as table linens, shower curtains and cubicle curtains.

v. Maintaining sufficient in-use inventory of ~~Hospital~~ Laguna Honda linen and institutional clothing through selection, purchase, storage and distribution.

vi. Environmental Services maintains and periodically reviews and revises its Laundry/Linen P&P Manual, which contains detailed procedures.

d. Requests

i. Call 4-4624 for linen services in the Main building

3. Mail and Messenger Services

a. Incoming mail: Monday - Friday, excluding City holidays, U. S. and City interoffice Inter-office mail is sorted to mailroom boxes and delivered to resident mailbox.

b. Outgoing mail: Outgoing mail is delivered twice a day to DPH Central Office for posting to the U.S. and City systems. Information: call 4-4624.

c. Messenger/courier service: Monday - Saturday, 8:00 a.m. - 4:30 p.m., excluding City holidays, service to 101 Grove Street Central Office, City Hall, SFGHMC, and some local agencies is available to selected Hospital Laguna Honda departments; call 759-46244-2622.

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

5. Shuttle Services

a. Hours of operation:

i. Five days per week from 6 a.m. to 6:30 p.m., Monday to Friday.

b. Scope of services:

i. Provides shuttle services between the Hospital Laguna Honda and the Forest Hill Muni station.

c. In the event that shuttle service is unavailable:

i. A sign stating that the shuttle service is unavailable will be posted by EVS in the lobby of the Pavilion and the Administration Buildings as well as in the operator's booth at the Forest Hill Muni station.

ii. The operator will announce that shuttle service is unavailable at the start of the affected shift.

ATTACHMENT:
None.

REFERENCE:
Environmental Services Policies and Procedures

Revised: 95/05/01; 03/04/22, 12/09/25, 16/01/1215/08/27 (Year/Month/Day)
Original adoption: 92/05/20

NURSE AND RESIDENT CALL SYSTEM

POLICY:

1. All resident calls for assistance must be answered promptly to identify and to address the resident's needs. Calls made from any emergency pull cord station (i.e., bathroom/toilet and shower/tub room), bed exit alerts, code blue alerts, and staff emergency calls must be answered immediately.

2. All Licensed Nurses (LNs), Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) will be assigned a SpectraLink® phone with corresponding resident assignments.

3. All LNs, CNAs, PCAs and designated HHAs will respond to the nurse call system whether routine or emergency by going to the call location or via SpectraLink® phone. Unit clerks can answer the ~~routine calls~~routine calls and may send forward the call and specific requests to the assigned nursing staff.

4. Designated HHA may answer to routine calls, bed exit alarms, and bath calls as requested by the LN and within the scope of HHA responsibilities.

5. All resident information on the Master Call Station is confidential. Any changes or updates regarding resident information can be made only by an authorized staff member.

6. Residents with limited or complete loss of hand mobility will be evaluated by a licensed nurse using adaptive devices guidelines for the correct adaptive device. Complex situations will be referred to Occupational Therapist (OT) for evaluation.

7. All ~~resident~~ bedside call lights must be checked ~~weekly~~ daily, and shower and bathroom call lights must be check weekly for proper function. ~~during bedside stripping as scheduled by the nurse manager and/or charge nurse.~~

PURPOSE:

To be able to communicate with residents and staff in order to meet the resident's need in a timely and prompt manner.

CHARACTERISTICS:

Each neighborhood has two master call stations, one for each nursing station in the South Residence Building (SRB) and the North Resident Building (NRB); Pavilion Mezzanine (PM) will have three master stations (PM-SNF; PR- Acute Rehab, PA- Acute Medical).

The Master Call Station allows staff to answer the resident's routine call, make calls directly to resident's room, and monitor requests that have been dispatched to staff members.

A. Types of Nurse and Resident's Call Stations

1. Master Call Station - comes with a computer (West Call Focus Care software), touch-screen monitor, mouse, keyboard, and connected telephone handset that is used to talk to the resident when answering a routine call. The touch screen has a floor map displaying all resident rooms and beds in the neighborhood.

2. Patient's Station - located in each room next to the resident's bed. All calls activated in patient's station, pillow speakers, and other adaptive nurse call devices will show in the Master station screen and will also be routed to the assigned caregiver's SpectraLink® phone.

3. Patient pillow speaker -connected to every patient call station, unless an adaptive call device is used. The pillow speaker is also used as remote control and speaker for the television. Pillow speakers or adaptive nurse call devices must be within the resident's reach.

4. Emergency pull cord station -located in every bathroom, toilet, shower or tub room in every neighborhood.

5. Staff call stations and staff duty stations – are located in commonly used areas by staff and residents such as living rooms at the end of each household, great rooms and staff lounge rooms.

6. Adaptive Nurse Call Device - any structure, technology, design, instrument, or equipment that enables a person with poor hand control or total loss of hand mobility place nurse calls. (Refer to NPP M 12.0 Adaptive Devices Operating Guidelines).

B. Hallway Light Illumination Patterns

For each type of call, a corresponding light illumination patterns in the hallway ceiling lights (zone and dome lights) will present visual cues to the staff for the location where a call has been made.

1. Zone lights –usually located at the end of each household in the living room area, nurses' stations, and great rooms. The zone light remains lit if there is an active call in the neighborhood.

2. Dome lights –located outside each resident rooms.

PROCEDURES:

A. Receiving and Responding to Calls

	Light Illumination Patterns	
Types of Calls	**Dome light**	**Zone light**
Code Blue Call	Flashing strobe lights (all colors)	Flashing strobe lights (all colors)
Staff Emergency Call	Flashing white light with solid green light	Flashing red light
Bath Call	Flashing white light	Flashing red light
Routine Call	Solid white light	Flashing white light

1. Code Blue Call – this highest priority call is intended only for life-threatening medical emergencies. This call overrides any routine call, bed exit alarm, bath call, or staff emergency call. This call must be responded to by any LN and nursing staff by going directly to the resident's location where the call was activated. A Code Blue Call can only be initiated at the patient station where medical emergency assistance is needed. This call can only be cancelled from the originating patient station after the Code Blue has been cleared by the Code Blue Team. Refer to LHHPP 24-16 (Code Blue).

2. Staff Emergency Call – high priority calls activated by pressing the "STAFF" button in the patient's station, staff-duty station or master call station. This call will override any routine call. The

assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the originating patient station.

Examples of staff emergency calls, but not limited to:
a. Resident found on the floor
b. Resident with unsafe behavior needing staff interventions
c. Any emergent situation that may require a second nursing staff for assistance

3. Bath Call – a high priority activated from the pull cord stations located in every resident's bathroom or toilet room, or tub room in every neighborhood. When activated, a "Bath" call appears on the Master Call Station and goes to the assigned caregivers' SpectraLink® phones. Assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the originating toilet station. Each shower pull cord station will state "Cancel at Toilet" (station).

4. Routine Call – regular call initiated from pillow speaker, patient's station, or other adaptive nurse call devices.

   a. For some simple requests, a pre-programmed "Send Request" button from the Master's Call Station will send a text message to the assigned caregiver's SpectraLink® phone indicating the request, room number and resident's name. Alternatively, a designated staff member answering the call from the Master Call Station can type a specific request, which will be sent to the assigned caregiver's SpectraLink® phone. Once a request is sent to a SpectraLink® phone, the request must be cleared by pressing the *cancel* button on the patient station. If the request is not cleared in a pre-determine time, the request will re-appear on the Master Call Station.

   b. Cord-out Call - activated when certain devices (i.e. pillow speaker, adaptive nurse call device, bed exit alarm, electric bed) are accidentally pulled out from the patient station, or disengaged from a connector, or unplugged from the electric outlet. These calls can only be cancelled from the resident's room by reconnecting items that were pulled out, disengaged or unplugged.

   c. Bed Exit Alarm –a priority call activated when a resident is trying to get out from his or her bed. When activated, a message is sent to the assigned Licensed Nurse, CNA, or PCA's SpectraLink® phone. The assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the resident's room by resetting the bed alarm.

B. Checking Function of Resident Call System

1. Testing the Patient Station: a call initiated from the resident's pillow speaker or adaptive device should appear as a routine call in the Master Call Station as well as on the assigned staff's SpectraLink® phones. The call should be answerable both at the Master Call Station and by a SpectraLink® phone, with both parties able to hear each other talking. The dome light outside of the resident's room should turn on.

2. Testing the Bath Call: when the bathroom pull cord is activated, the call should appear as a bath call in the Master Call Station as well as the assigned staff's SpectraLink® phones with the room number. The dome light outside the resident's room should turn on.

   a. For the bath calls made from the spa rooms and public toilets within the neighborhood, a designated group of nursing staff are assigned to respond when the pull cord is pulled. The

same steps should be followed as stated above when testing pull cords from the spa room and public toilets within the neighborhood.

3. Document ~~weekly~~ in the DNCR ("Interventions" page) upon completion of checking:

    a. Daily for the bedside call lights
    b. Weekly on bed stripping days for shower and bathroom call lights

4. Reporting of Non-Working Resident Call System

    a. Report to Facility Services if the nursing staff is unable to hear a call to or from the Master Station, Patient Call Station, Patient Pillow Speaker, Adaptive Nurse Call Devices, or from SpectraLink® phone.
    b. Report to Facility Services is unable to receive a bath call message on the SpectraLink® phone or in the Master Call Station, if the room number displayed was incorrect, or if the pull cord needs repair.
    c. Report to Facility Services if the dome light is not working.
    d. Contact Central Supply for replacement pillow speakers.

C. Downtime Procedures

During downtime, a page will be sent to all the Charge Nurse pagers indicating which Downtime System Manual on the Nursing Intranet should be followed.

ATTACHMENTS:

Attachment 1: Nurse Call System User Guidelines
Attachment 2: Wireless Phone Operating Guidelines
Attachment 3: Step by Step Procedure when Responding to Calls
Attachment 4: DNCR (Intervention Page): ~~for~~ Checking Call Lights

REFERENCES:

West-Com Nurse Call Systems, Inc., West-Call® FocusCare® Software User's Guide Version 1.1.8, December, 2009
Avaya 3645 Wireless IP Telephone Reference Guide

CROSS REFERENCES:

LHHPP 24-16 Code Blue

NPP D9 3.0 Bed Stripping and Bedside Cleaning
NPP M 12.0 Adaptive Devices Operating Guidelines

Original: 10/2010

Revised: 07/26/2011; 09/24/2013; 03/10/2015; 10/16/15

Reviewed: ___________ ~~03/10/2015~~

Approved: ~~03/10/2015~~___________

Daily Nursing Care Record

Interventions

Record initials in the date column corresponding to the shift that treatment was administered.

Legend X = Not Performed, R = Refused (Response of X or R requires nurse notification and supplemental note).

Intervention	Shift	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Test the Resident's call light devices daily	N																															
	D																															
	E																															
On weekly bed strip days, test ALL the Resident's call lights (bathroom, shower & routine)	N																															
	D																															
	E																															
On bath days, check if the resident's nails need trimming: C=check T=trimmed R=refused																																
	D																															
	CTR																															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

MR 343A (REV 6/11)

UNIT: BED: MONTH/YEAR: **October 2015**

MR 343A i (REV 6/11)

ADDRESSOGRAPH LHH 1760

ORAL MANAGEMENT OF NUTRITIONAL NEEDS

POLICY:

1. Physician orders are required for diets, nutritional supplements,~~ and~~ swallowing evaluation, and aspiration precautions (standard precautions and specialized feeding plans).

2. Nursing staff is~~are~~ responsible to monitor that residents'~~s swallow~~ safety related to eating as well as ~~and receive~~ adequate nutritional intake.

3. Nursing staff will inform the dietician and physician regarding unintended weight loss or gain.~~The nurse reports to the dietitian and physician any unintended weight loss or gain that is greater than 5% or more in 30 days, 7.5% or more in 90 days and 10% or more in 180 days.~~

4. Family, volunteers, and visitors will be ~~educaed~~educated regarding permitted food and beverages. ~~are instructed to check with the licensed nurse prior to offering the resident any food or beverages.~~

5. ~~For a resident on~~ A~~a~~spiration precautions will be documented in the resident care plan.~~, the licensed nurse documents that the resident is on aspiration precautions on the front card of the care plan.~~

PURPOSE:

To promote adequate and safe nutrition and hydration.

PROCEDURE:

1. On admission and throughout the resident's stay, the Licensed Nurse (LN) will monitor all residents for ability to eat safely and for any signs or symptoms of swallowing difficulties or changes in the resident's ability to eat /swallow.

2. The physician and dietitian will be notified of any nutrition ~~When nutritional~~ and/or swallowing difficulties.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:

   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   ~~a.~~c. 10% or greater over 180 days ~~are noted, the physician and dietitian are notified.~~

~~2.~~4. Nursing staff will verify that the meal/snack is consistent with the resident's diet as ordered by the physician.

~~3.~~5. Nourishment is to be served by nursing staff between meals, at bedtime and upon resident's request.

6. All family, volunteers and other visitors will be instructed to speak with the nurse prior to offering the resident any food or beverages.

~~4.~~7. Refer to LHHPP 26-02: Management of Dysphagia and Aspiration Risk.

~~5.~~8. Nursing staff assigned as Line of Sight staff during meals, will have the following responsibilities:

a. Designated staff will w~~W~~wear a designated vest.~~,~~
b. Designated staff will s~~S~~stay in the ~~area of the~~ g~~G~~reat r~~R~~oom during meals (from beginning to end; until the last resident in the great room is finished eating)~~where all residents eating are visible~~.
c. Designated staff will ensure that residents are seated ~~at their~~at an appropriate table/seat.~~Sstay in the great room during meals (from beginning to end, until the last resident in the great room is finished eating)~~.
~~c.~~d. Designated staff will continuously scan the area of the Great Room to monitor that standard aspiration precautions (see LHHPP 26-02) are being followed.~~,~~
~~d.~~e. Designated staff will monitor that staff assisting r~~R~~esident who are on a~~with~~ ~~have the~~ s~~S~~pecialized f~~F~~eeding p~~P~~lan, are following the plan. ~~(~~Precautions are printed on the resident's tray ticket for easy reference~~SFP) have a pink dome to alert staff and SFP is written on the resident's ticket tray~~ and the meal tray has a pink plate cover.~~.~~ ~~Binder available and shall carry out the specialized feeding plan of each resident,~~
~~e.~~ Designated staff will monitor and intervene as necessary when patients are eating unsafely or showing signs/risk of aspiration (e.g., excessive coughing, excessive throat clearing, impulsive eating behavior, etc.).~~For those units with seating plan ensure that residents are seated in their proper seating arrangements.,~~
f. ~~Iintervene immediately if any resident is exhibiting unsafe eating behavior.~~

9. T~~o prevent distraction when supervising residents during meal time, t~~he designated Line of Sight staff will~~should~~ not be assigned other responsibilities during meal time nor assist individual residents during meal time as he or she will not be able provide adequate supervision to the other residents.~~to feed a resident~~.
~~or other responsibilities during meal time.~~

~~6.~~10. After the meal is completed, the Nursing Assistant will clean the resident's hands, face and clothing as needed. Keep resident sitting upright for at least 20 minutes after the meal. If residents must lie down, position on the side.

11. Food Storage

a. All foods stored in the refrigerator are to be covered, labeled, and dated. Unopened items will have a stamped expiration date. Opened items will be dated with the date the item was opened.
b. Uneaten food from the meal tray should be discarded or sent back to kitchen for disposal.
c. Milk should be discarded after one hour at room temperature.
d. Nourishment refrigerators are to be kept secured. Galley refrigerators are secured behind a locked door. Great room refrigerators will be locked.

12. Documentation

a. Nursing Assistant will calculate and document in the Daily Nursing Care Record (DNCR) the resident's meal intake. Report to Licensed Nurse if meal intake is less than 50%.
b. If a supplement is given per physician's order, the amount ~~eaten~~of the supplement consumed is documented in the Treatment Administration Record (TAR).
c. Resident's diet, standard aspiration precautions, adaptive equipment used for eating, and dining preferences are documented in the Front Card of Resident Care Plan.
d. In addition to standard aspiration precautions , the speech pathologist may develop a Specialized Feeding Plan (SFP) for some of the residents who are at risk for aspiration (Refer to LHPP26-02: Management of Dysphagia and Aspiration Risk). The special precautions will

be listed on the resident's tray ticket for easy reference by nursing staff. A copy of the SFP will be placed by the speech pathologist is the RCP.

a. e. If resident is on fluid restrictions, fluid intake is documented in the TAR and tallied by P.M. shift nightly.

All foods stored in the refrigerator are to be covered, labeled, and dated with the date when the item was opened.
Uneaten food should be discarded from the refrigerator after 24 hours.
Milk should be discarded after one hour at room temperature.
Any uneaten food from the tray will be sent back to the kitchen.

a. Nourishment refrigerators are to be kept locked.

Documentation

1. .

2. Resident's diet, precautions, adaptive equipments used for eating, and dining preferences are documented in the Front Card of Resident Care Plan.

3. If resident is on fluid restrictions, fluid intake is documented in the Treatment Administration Record (TAR) and tallied by P.M. shift nightly.

CROSS REFERENCES:

LHHPP 26-02 Management of Dysphagia and Aspiration Risk
LHHPP 26-04 Resident Dining Service

NPP B 5.0 Color Codes- Resident Identification
NPP G 3.0 Intake and Output

Revised: 9/2005, 10/2009, 1/2010, 07/26/2011, 12/2014; 03/10/2015; 11/06/2015

Reviewed: 03/10/2015_____________

Approved: 03/10/2015_____________

~~PRESSURE ULCER PREVENTION AND~~ASSESSMENT, PREVENTION, AND ~~AND~~ MANAGEMENT OF PRESSURE ULCER ~~TREATMENT~~

POLICY:

~~1. The Registered Nurse (RN) is responsible for assessing pressure ulcer risk and skin, and for assessing and staging pressure ulcers. The RN contributes nursing expertise in developing, implementing and evaluating interdisciplinary plans of care that address pressure ulcer risk and treatment.~~

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure ulcer (PU) on admission and/or following any decline in condition that may increase the resident's risk of developing a pressure ulcer.

2. Upon resident's intra~~er~~-facility relocation and discharge to acute hospital (including Pavilion Acute), the licensed nurse is responsible for conducting skin checks and ~~provides hand-off report~~complete skin section (see Interfacility/LHH Body Diagram form) ~~transfer documentation~~ to the receiving neighborhood/facility, for any presence of pressure ulcers/complex wounds.~~The Licensed Nurse is responsible for monitoring residents at risk for pressure ulcers, for observing, reporting and documenting wound status, for implementing plans of care that address pressure ulcer risk and treatment, and for collaborating with RNs in the evaluation of related plans of care.~~

3. Upon identification of PU(s), two RNs are required to verify and accurately stage the ulcer(s).

4. When a resident is transferred to Paviliion Mezzanine Acute (PMA), the sending SNF licensed nurse and the receiving PMA RN will together assess the skin.

5. The Certified Nursing Assistant (CNA) is responsible, within his/her scope of practice, for observing and reporting changes in residents' skin status, and for implementing planned interventions. ~~that address identified pressure ulcer risks and foster wound healing.~~

PURPOSE:

To provide guidelines to nursing with assessment and management of pressure ulcers~~To maintain skin integrity in residents at risk for pressure ulcers and to ensure that a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing~~.

PROCEDURE:

~~**A. Preventive Measures**~~
~~1.~~
~~Refer to Laguna Honda Policy and Procedure 20-54: Pressure Ulcer Management~~

1. Prevention of Pressure Ulcer for Resident at Risk

a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration or wound drainage as much as possible. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).

b. Skin check: nursing assistants are to thoroughly check the resident's skin at least once daily, paying particular attention to bony prominences and are to report changes to the charge nurse or the designee. This procedure may be incorporated into the resident's daily hygiene care.

c. Positioning: position using the 30-degree rule — no greater than 30 degrees on either side, or the head of the bed should not be elevated more than 30 degrees when possible. Avoid positioning directly on trochanter or existing ulcer.

d. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Repositioning clock or written schedule (depending on the resident's needs) may be utilized to monitor repositioning.

e. Caution when moving resident. Avoid shearing/friction by using lifting devices such a trapeze or bed linen to move (rather than drag) residents who cannot assist during transfers and position changes.

f. Positioning devices: use wedge, pillows, and pads to keep bony prominences from direct contact with one another.

g. Support surfaces: nursing will apply a pressure-relieving support surface (bed/wheelchair) per protocol and/or specialized mattress when needed after evaluation by wound care CNS or designee. If re-evaluation is needed inform wound care CNS or designee. (refer to LHPP 24-03 Specialized Bed And Support Surface Equipment).

h. Protective devices:
   i. Protectors for ankle and elbow to minimize friction.
   ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels.
   Do not put the pillow directly under the knees.
   iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
   iv. Foam arm rest covers (available in central supply room) for wheelchair arms can be used.

i. Careful placement in chairs: position chair-bound resident in good postural alignment, distribution of weight, balance and pressure relief.

   i. Refer to occupational therapy for evaluation of appropriate seating device.
   ii. Avoid sitting directly on the pressure ulcer.
   iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
   iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
   v. Instruct or assist resident to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes, if they are able.
   vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of Pressure Ulcer

a. The Registered ~~Nurse Licensed nurse~~ will complete the facility approved ~~designated~~ tool for pressure ulcer risk assessment on ~~at~~ admission, on ~~post-admission~~ days 3, 7, 14, 21, and 28 post admission, quarterly, annual, and/or following any decline in condition.

b. The charge nurse or the designee ~~NNurse Mmanager/licensed nurse team leader~~ will inform the RCT of any resident identified at risk for pressure ulcers, and develop an initial care plan. The RCT will review and contribute to the care plan as needed.

c. The charge nurse or the designee ~~Nnurse Mmanager/licensed nurse team leader~~ will ensure that the plan of care is reviewed with nursing staff and ~~will~~ ensure through direct supervision that the plan of care is being implemented.

d. The ~~Registered Nurse Licensed nurse~~RN will assess the ulcer(s) when present. ~~and/or~~ T~~t~~he licensed vocational nurse (LVN) may assist in data collection under supervision of RN:

   i. location
   ii. size (length, width, depth in cm)
   iii. stage of ulcer(s)
   iv. presence and quality of granulation tissue
   v. whether the wound edge around the ulcer is hard, thick, rolled or white-gray tissue, macerated edge, or open edge (healthy edge)
   vi. presence of pain, exudate, slough, necrotic tissue and odor
   vii. sinus tracts, tunneling, undermining
   viii. ~~surrounding skin~~periwound for erythema, ~~or~~ warmth, ~~around the wound edge,~~ maceration, ~~-~~or induration
   ix. signs of wound infection , such as ~~:~~ tenderness of surrounding tissue, edema or swelling, purulent drainage or foul odor

Indicators of a deteriorating pressure ulcer include increase in ulcer size, increase in exudate, loss of granulation tissue, purulent drainage and development of slough, necrosis, eschar or odor.

e. The Registered ~~Nurse Licensed nurse~~ will reassess pressure ulcer(s), at least weekly, to determine whether the prescribed treatment is working and document on the facility approved wound assessment record (WAR)~~form~~ until healed. A clean pressure ulcer should show evidence of some healing within two weeks.

f. The Registered N ~~urse Licensed nurse~~ will reevaluate the treatment plan weekly or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the ulcer fails to respond to treatment, refer the resident to the physician/wound care Clinical Nurse Specialist (CNS).

3. Management of Pressure Ulcer

a. Following detection of a pressure ulcer, the charge nurse or designee ~~Nnurse Mmanager/licensed nurse team leader~~ will promptly:

   i. notify the neighborhood physician or if immediate treatment is needed, on-call physician ~~and a treatment plan will be implemented within eight (8) hours;~~
   ii. notify wound care CNS
   iii. notify the dietitian ~~within 24 hours;~~
   iv. notify the resident and / or Surrogate Decision Maker (SDM)~~DM within forty-eight (48)~~

~~hours;~~

v. complete facility approved ~~a~~ WAR~~ound Assessment Form (wound assessment form and progress note; and~~

vi. complete an Unusual Occurrence form

vii. s~~S~~chedule Resident Care Conference

b. Develop/revise plan of care for prevention and treatment of the ulcer(s).

c. The RN~~egistered Nurse A licensed nurse~~ will assess pressure ulcer(s) weekly. The LVN may assist in gathering ~~collecting~~ data under supervision of the R~~egistered~~ N.

d. The RN ~~CT~~ will reevaluate the treatment plan if the ulcer(s) fails to show evidence of healing within two weeks, or when the ulcer shows signs of deterioration.

e. The A~~a~~ttending P~~p~~hysician in conjunction with the RN ~~-~~will evaluate non-healing and worsening ulcers and refer to the Plastic Clinic/Wound Care CNS.

4. Documentation of Pressure Ulcer

a. Admission/~~Interfacility relocation:~~: ~~-~~document condition of skin and complete the pressure ulcer risk assessment on the Nursing Admission Assessment form.

b. Intra-facility relocation: document condition of skin and complete the ~~pressure ulcer risk assessment on the Relocation Form~~facility approved Body Diagram form.

c. Annually: document condition of skin as part of Minimum Data Set (MDS). Complete the facility approved pressure ulcer risk assessment tool.

d. Discharge to ~~Interfacility acute unit~~/outside facility or i~~I~~ntra-facility acute unit: document condition of skin and pressure ulcer(s) and complete the body diagram ~~form~~ with ~~on~~ the approved inter-facility transfer/ LHH body diagram form.

e. Document ~~Complete~~ the ~~facility~~ required Pressure Ulcer Risk assessment tool on days 3, 7, 14, 21, ~~28 post~~28-post admission, quarterly and following a significant decline in condition.

f. Resident Assessment Instrument (RAI): When a pressure ulcer is triggered as a Care Area Assessments (CAA) ~~RAP~~ Problem Area, the MDS Coordinator will:'

i. Utilize the CAA guidelines to identify additional areas needing assessment.

ii. Document the assessment in the CAA notes, including the decision to care plan or not.

iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a residents develops a stage 2 or higher pressure ulcer.

g. Resident Care Plan: If the resident is identified as being at risk for pressure ulcers as determined using the facility approved pressure ulcer risk assessment tool, or has a pressure ulcer, a comprehensive, interdisciplinary care plan is developed that:

i. identifies problems (i.e., PU risk factors and/or presence of ulcer),

ii. develops individualized goal(s),

iii. develops interventions to address prevention or treatment.

h. SNF and Acute care units: Wound assessments are done weekly and/or when there is a decline in the condition of the wound. These assessments are documented on the facility approved WAR.

i. DNCR notes: Nursing Assistants~~Direct caregivers~~ are to document any changes in skin condition they observed on the DNCR record, including the name of the licensed nurse notified.

j. Weekly or monthly nursing summaries: Summaries include assessment of any new resident's risk factors for developing pressure ulcer(s) as well as evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.

k. Notification: Document all notification to the physician, wound care CNS, dietitian and family or SDM when a pressure ulcer is detected ~~,~~ and when the ulcer shows no evidence of healing.

l. Resident education / counseling: Resident teaching or counseling related to prevention/management of pressure ulcers is to be documented in the progress notes/WAR~~wound assessment record~~, and/or resident care plan.

APPENDICES:

Appendix 1: Definition of Pressure Ulcer and Intervention
Appendix 2: Staging of Pressure Ulcer
Appendix 3: LHH Skin Care Formulary
Appendix 4: LHH Wound Care Formulary

REFERECES:

Acute & Chronic Wounds: Current Management Concepts, Elsevier, 4th edition, 2012
Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008
Sizewise

CROSS-REFERENCES:

LHHPP 24-15 Prevention and Management of Pressure Ulcer
Nursing Policy C 1.0 Admission and Readmission Procedures
Nursing Policy C 1.2 Relocation Procedure
Nursing Policy C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
Nursing Policy C 4.0 Notification for Change in Resident's Status

~~1. **Newest Research recommends:**~~
~~2.~~
~~3. **use of no-rinse soap during incontinent care in order to maintain protective skin ph.**~~
~~4.~~
~~5. **use of skin barriers and moisturizers to protect skin**~~
~~6.~~
~~7. **turning resident without friction**~~
~~8.~~
~~9. **use of disposable absorbent diapers for incontinent residents, who have been assessed to benefit to the use of disposable diapers**~~

B. Pressure Ulcer Management

1. Nursing staff reports changes in skin condition to the team leader or charge nurse.

2. The team leader or charge nurse evaluates skin for signs and symptoms of pressure injury.

3. When pressure injury is identified an RN
   a. assesses the ulcer, stages it and initiates a Wound Assessment Record (WAR)
   b. notifies the nurse manager, physician, and family or surrogate decision maker, and contacts other team members as needed to initiate a plan of care
   c. collaborates with the physician regarding treatment and obtains orders for all pressure ulcers that are stage II or greater.
   d. completes and submits an Unusual Occurrence form for all pressure ulcers.
   e. assesses/reassesses the resident for pressure ulcer risk factors.
   f. initiates or revises care plan entries to address risk factors and wound treatment strategies
   g. documents the assessment and follow up in the Progress Notes.

4. During initial identification and planning related to the pressure ulcer, nursing staff will follow procedures set forth in Hospitalwide Policy and Procedure 20-54: Pressure Ulcer Management:
   Section C: Management of pressure ulcer
   Section D: Documentation of pressure ulcers

5. In developing implementing and evaluating a plan of care, nursing staff should refer to Nursing Practice Guideline: Pressure Ulcers (Appendix 1), and consult with other knowledgeable clinicians.

C. Documentation and reporting

1. Treatment Sheet. Document implementation of wound care orders.

2. Wound Assessment Record. Document a complete wound assessment weekly and when deterioration of the wound is observed or suspected.

3. Report any undue bleeding, untoward reactions or wound deterioration to the physician. Chart resident's reaction and response to pain, change in wound condition and/or physician notification.

4. Weekly Summary: Chart the progression or regression of healing of the wound.

ATTACHMENTS

Appendix 1: Nursing Practice Guideline: Pressure Ulcers

CROSS REFERENCES

"Solutions: Algorithm book" on each Unit.
LHPP 20-54: Pressure Ulcer Management
LHPP 60-04: Unusual Occurrences

Document originated: 11/2001.

~~Document revised:~~

Revised: 2/2005; 3/2008; 12/2015

Reviewed:

Approved:

APPENDIX 1: Definition of Pressure Ulcer and Intervention

1. Pressure Ulcer: Any lesion caused by unrelieved pressure, friction, shear, or moisture resulting in damage of underlying tissue. PU(s) usually form on parts of the body over bony prominences that bear weight.

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2. Stage 1 PU: Intact skin with nonblanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. In darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

3. Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as intact or open/ruptured serum blister. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

4. Stage 3 Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

5. Stage 4 Pressure Ulcer: Full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present of some parts of the wound bed. Often include undermining and tunneling.

6. Unstageable: Full-thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown), and/or eschar (tan, brown, or black) in the wound bed.

   a. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and stage, cannot be determined.
   b. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the "body's natural (biologic) cover" and should not be removed.

7. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue.

Commented [IM1]: Per NEC and Fatima, delete and keep table

Stage	Description	Interventions
Suspected Deep Tissue Injury (DTI)	Purple or maroon localized are of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep Tissue Injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment	1. Position patient off the affected area to relieve pressure and maximize blood flow to the area. 2. **Sacral** suspected DTI: a pressure redistribution surface may be appropriate to prevent ulcer from progressing. **Heels** - float heels with pillows (place pillow lengthwise under the calf so heels float and do not touch pillow or bed surface). 3. Dressing may be placed for protection, if appropriate. 4. This wound can evolve to a full thickness wound and should be reassessed for wound care needs as this occurs.
Stage I	Intact skin with non-blanching redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" person (a heralding sign).	1. Position patient off the affected area to relieve pressure and maximize blood flow to the area. 2. Dressing may be applied for protection, if appropriate. 3. Include in hand-off at end of shift report and to accepting units so interventions can be continued. 4. **Sacral:** a pressure redistribution surface may be appropriate to prevent further progression of the ulcer (consult with wound care CNS). **Heel**: float heels with pillows (place pillow lengthwise under the calf so heels float and do not touch pillow or bed surface).
Stage II	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury	1. A pressure redistribution surface may be appropriate (refer to wound care CNS). 2. **Heels**: float heels with pillows/heel protectors. 3. Keep open skin clean and moist to facilitate healing. 4. Refer to wound care options for dressings/treatments. 5. Patients with incontinence/frequent loose stool use skin barriers. Apply antifungal before the barrier cream if there is a fungal infection present (per MD order).

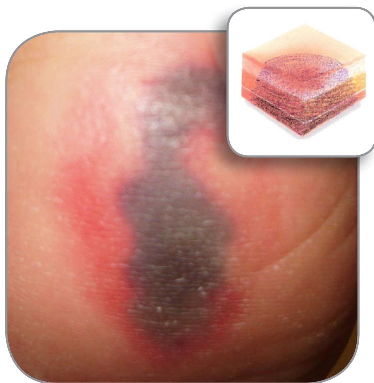
Stage	Description	Interventions
Stage III	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.	1. Contact unit CNS and obtain a wound consult. 2. Refer to reporting section if pressure ulcer is hospital acquired. 3. Refer to wound care options for dressings/treatments. 4. Pressure redistribution surface refer to bed decision tree. 5. Float heels with pillows. (place pillow lengthwise under the calf so heels float and do not touch pillow or bed surface).
Stage IV	Full thickness tissue loss with exposed bone, tendon or muscle. Slough and/or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, or joint capsule) making osteomyelitis possible	1. Contact unit CNS and obtain a wound consult. 2. Refer to reporting section if pressure ulcer is hospital acquired. 3. Refer to wound care options for dressings/treatments. 4. Pressure redistribution surface (refer to wound care CNS). 5. Float heels with pillows. (place pillow lengthwise under the calf so heels float and do not touch pillow or bed surface).
Unstageable	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, brown) and/or eschar (tan, brown, black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined. Stable (or adherent intact without erythema or fluctuance) eschar on	1. Contact unit CNS and obtain a wound consult. 2. Pressure redistribution surface (refer to wound care CNS). 3. Refer to wound care options for dressings/treatments. 4. Surgical consult as needed for debridement. 5. Float heels with pillows. (place pillow lengthwise under the calf so heels float and do not touch pillow or bed surface).

	the heels serves as "the body's natural (biological) cover" and should not be removed	

Revised: 05/01/11 (Year/Month/Day)
Original adoption: 00/08/15

PRESSURE ULCER:
Definition & Stages

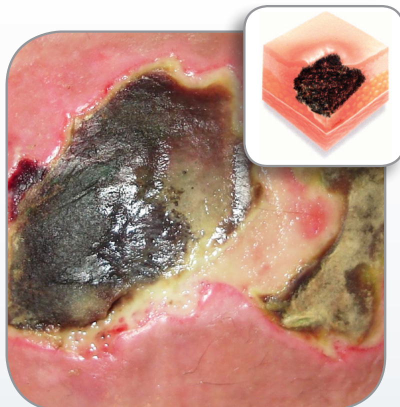
Definition:
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.



Location: Heel, © NPUAP 2010

Suspected Deep Tissue Injury

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



Location: Hip, © NPUAP 2010

Unstageable

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

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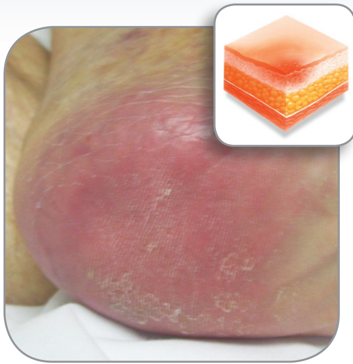
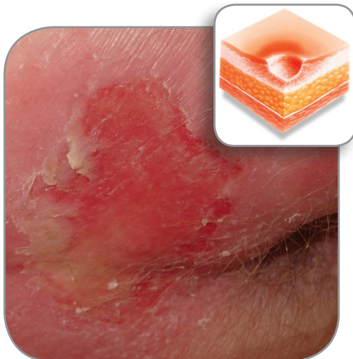


Location: Heel, © NPUAP 2010

Stage I

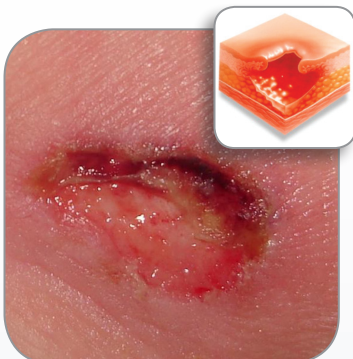
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).



Location: Buttocks, © NPUAP 2010

Stage II

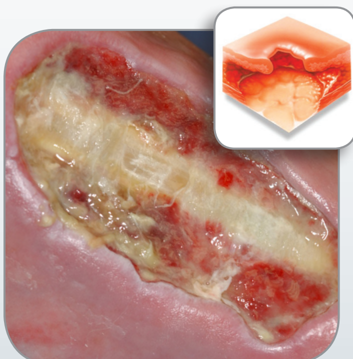
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury.



Location: Ischium, © NPUAP 2010

Stage III

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.



Location: Shin

Stage IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

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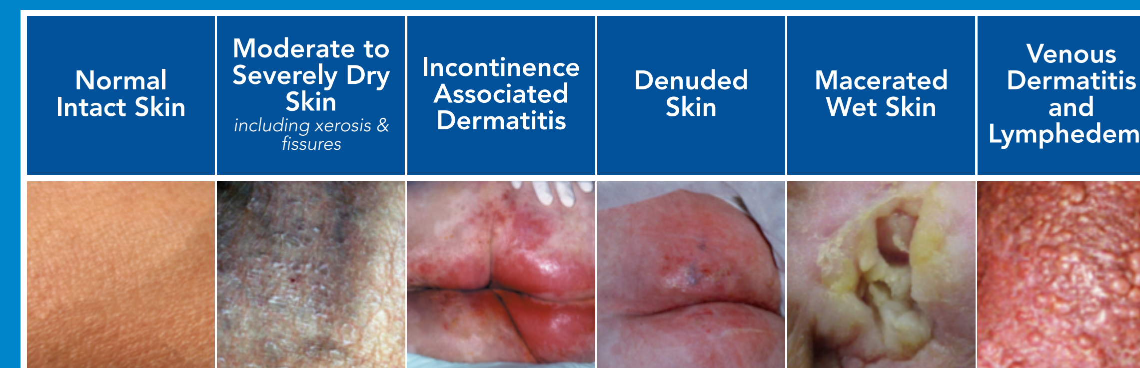
Laguna Honda

SKIN CARE FORMULARY



Category	Product	Normal Intact Skin	Moderate to Severely Dry Skin *including xerosis & fissures*	Incontinence Associated Dermatitis	Denuded Skin	Macerated Wet Skin	Venous Dermatitis and Lymphedema
Cleanser	**Remedy with Phytoplex Hydrating Foaming Cleanser** Gentle, effective cleansing and conditioning pH balanced for every day use. Strong enough for removing barrier pastes, heavy creams, blood and fecal material. Tear Free, Hypoallergenic, & Non-Sensitizing .	●	●	●	●	●	●
Barrier – Protection	**Remedy Dimethicone Skin Protectant** Provides a breathable barrier that protects against moisture and excessive transepidermal water loss (eTEWL). Doubles as an excellent long-term moisturizer for use on sensitive skin. pH balanced and enhanced with Olivamine®.	●	●	●			
Barrier – Protection	**Soothe & Cool INZO** Leaves a non-greasy, invisible moisture barrier with a non-petrolatum formula that won't obstruct brief pores. Contains 5% dimethicone and 5% zinc oxide, as well as vitamins A, D & E and aloe. Specially formulated without dyes or perfumes. Ideal under tape.	●	●	●	●	●	●

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THE EDUCARE® HOTLINE AT: 1-888-701-SKIN (7546)

www.medline.com/Woundcare

WOUND CARE FORMULARY

Laguna Honda

Category	Product Type	Product	Shallow and Minimal/No Drainage	Shallow and Draining	Deep and Minimal/No Drainage	Deep and Draining	Venous Leg	Slough	Eschar	Skin Tears	IV Site	Burns
DEBRIDEMENT	Honey Wound Dressing	TheraHoney® Gel MNK0015* TheraHoney Gauze MNK0077*	✔	✔	✔	✔	✔	✔	✔			✔
INFECTION/INFLAMMATION	Silver Hydrogel	SilvaSorb® Gel (MSC9301EP)*	✔		✔		✔					✔
INFECTION/INFLAMMATION	Gelling Fiber with Silver	Opticell™ AG+ Sheet (MSC9845EP)* Opticell™ AG+ Rope (MSC9818EP)*	✔	✔	✔	✔	✔					✔
MOISTURE BALANCE	Hydrogel	Skintegrity® (MSC6102)*	✔		✔			✔	✔	✔		
MOISTURE BALANCE	Hydrocolloid	Exuderm OdorShield™ (MSC5544)*	✔									
MOISTURE BALANCE	Transparent Film	Suresite® Window (MSC2302)* Suresite® Matrix (MSC2204)*									✔	
MOISTURE BALANCE	Superabsorbent Dressing	Optilock® (MSC6455EP)*		✔		✔	✔	✔				✔
MOISTURE BALANCE	Silicone Bordered Foam	Optiva™ Gentle (MSC6644EP)*		✔		✔	✔	✔	✔	✔		✔
EDGE/ ENVIRONMENT	Collagen	Puracol® Plus (MSC8622EP)*	✔	✔	✔	✔	✔					✔
SUPPORTIVE PRODUCTS	Wound Cleanser	Skintegrity® (MSC6008)*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
SUPPORTIVE PRODUCTS	Skin Protectant	SurePrep® Wipe (MSC1500)*	✔	✔	✔	✔	✔		✔	✔	✔	
SUPPORTIVE PRODUCTS	Compression Therapy	FourFlex® (MSC4400) Medigrip™ (MSC9503)*					✔					
SUPPORTIVE PRODUCTS	Retention Tape	Medfix™ EZ (MSC4102)*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
SUPPORTIVE PRODUCTS	Silicone Contact Layer	Versatel® (MSC1734EP)*	✔	✔	✔	✔	✔	✔	✔	✔		✔

* Other sizes available.

DEBRIDEMENT | INFECTION/INFLAMMATION | MOISTURE BALANCE | EDGE/ENVIRONMENT | SUPPORTIVE PRODUCTS

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PROTOCOL FOR USING PSYCHOTROPIC MEDICATIONS ~~ON UNANTICIPATED AND/~~ FOR EMERGENCY BEHAVIORAL SITUATIONS ~~BASIS~~

~~POLICY:~~

This protocol is followed when it is necessary to administer a psychotropic medication on an unanticipated or emergency basis, (for example, a resident develops any behavior that poses a risk of harm to self or others).

Selection of therapy for individual patients is ultimately based on physicians' assessment of clinical circumstances and resident needs. This protocol is not intended to interfere with clinical judgment. Rather, it is intended to assist practitioners in providing consistent, high quality care.

NOTE: As needed or PRN drug use is considered planned when its use is anticipated, the indication for use is clearly specified and the conditions ~~requiring it~~ are not emergent. For PRN psychotropic use in these cases, this protocol does not apply**.**

PURPOSE:

1. To ensure appropriate prescribing and administration of psychotropic medications if used on an unanticipated or emergency basis.

2. To ensure adequate monitoring and observation of residents.

PROTOCOL:

~~This protocol is followed when it is necessary to administer a psychotropic medication on an unanticipated or emergency basis, (for example, a resident develops any behavior that poses a such as extreme agitation posing potential risk of harm to self or others):~~

1. The clinical staff will ~~evaluate~~ assess the resident and document ~~to determine~~ any physiological and/or environmental "triggers"~~".~~ ~~If possible, environmental & behavioral interventions are tried **before** psychotropic drugs.~~. All non pharmacological interventions should be attempted and well documented before the administration ~~of any~~of any medications.

2. Emergency use of psychotropic medications

~~**Emergency use of psychotropic medications**~~

   a. In an emergency situation, psychoactive medications may be ordered by the physician in writing when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

   b. There should be appropriate documentation in the chart of the specific circumstances for which the medication is prescribed.

   c. Nursing staff shall monitor, document, and notify the provider of ~~for~~ the effectiveness of the medications as well as any ~~and any~~ adverse reactions.~~ Documentation and notification to the provider.~~

d. Emergency orders will be continued only as required to treat the emergency situation.

e. Before continuing psychoactive medications which was initiated on an emergency basis, informed consent must be obtained. For residents without a Surrogate Decision Maker (SDM), the Resident Care Team (RCT) must meet to discuss the issue and provide consent.

f. When psychoactive medications has been used as a chemical restraint in an emergency situation and the patient is unable to consent and there is no surrogate, informed consent must be obtained through the RCT (Epple refer to LHHPP 25-10 procedure).

g. The form, Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use (MR 35535???), will be completed when psychoactive medications are used in emergency situations.

2.3. When administration of a psychotropic medication is necessary on an unanticipated or emergency basis:

a. The nursing supervisor shall be notified.
 immediately.
b. The resident shall be monitored for -medication effectiveness and any side effects after following administrationfollowing administration of the medication.
 (e.g. behaviors, outcomes and side effects).
a.c. A physician shall observe the effect of the medication by personally visiting the resident and /or consulting with the licensed nurse observing the resident.

b.d. The Licensed Nnurses will documentnote the target behavior symptom identified triggering factors, interventions, outcomes and any observedactual drug side effects on the Behavior Monitoring Record (BMR).

c.e. The RCIDT shall evaluate and update -the resident care plan in order to determine areas additional of behavioral intervention needs.

3. The Licensed NNurses will discuss with the physician any recommendations for any futherfurther evaluation by the psychiatric team. Where the nature of the mental illness diagnosis, behavioral intervention plan, or psychotropic medication regimen requires more specialized and expert treatment, the primary physician shall request a consult by a psychologist or psychiatrist to develop and implement an appropriate treatment plan
4.

Cross Reference CROSS REFERENCES:

LHHPP 25-10 Use of Psychoactive Medication
Form MR 355 Emergent/Unplanned Psychotropic: Drug Use Assessment and Progress Note

ReferenceREFERENCE:

The Long Term Care Survey CMS Redbook(2009)

New documentOriginal: 11/2008. Prepared by N.E.O. MH and Pharmacy DW.

Revised: 01/12/2016 Andre Michaud 2/29

Reviewed: 01/12/2016__________

Reviewed by Andre_________ and no revision recommended at this time.

Approved: 01/12/2016___________

For Ghe use only:
Date sent to Policy Reviewer **01/25/14**
Date received from Policy Reviewerreviewed by CNS 02/21/14 _____________
Date reviewed by NEC _________
Date approved by NEC _________
Date routed to MEC ___________
Date emailed to Karina ________

LAGUNA HONDA HOSPITAL **03.01.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY QUALITY ASSESSMENT AND IMPROVEMENT

Policy:

The Pharmacy Department shall participate in the overall Hospital quality assessment and improvement program. The Pharmacy Director shall coordinate this participation and ensure that the review and evaluation of quality for selected important aspects of care are reported to the hospital-wide QA Committee and/or the Pharmacy & Therapeutics Committee, and to the appropriate hospital administrators.

Purpose:

To provide high quality Pharmaceutical Services to all residents and staff, consistent with the Department's Mission.

MISSION STATEMENT:

The mission of Laguna Honda Hospital is to provide or ensure a continuum of health care services for senior and disabled residents of San Francisco.

"The mission of the Laguna Honda Hospital Pharmacy Department is to provide reliable, consistent, comprehensive and cost-effective pharmaceutical services to the residents and staff of the Hospital. These services shall be provided to promote safe and effective use of medications, and to advise, educate and offer a learning environment for students, volunteers and other health care providers. The Department is committed to assuring quality outcomes by emphasizing inter-disciplinary teamwork, continuous improvement, drug therapy expertise and sound financial management."

IMPORTANT ASPECTS OF CARE AND SERVICES PROVIDED:

1. Accurate dispensing of medications
2. Timely dispensing of medications
3. Providing counseling for residents discharged with medications
4. Providing drug information to residents and staff
5. Promoting safe and effective drug therapy

I. SPECIFIC PHARMACY QUALITY ASSESSMENT & IMPROVEMENT ACTIVITIES:

A. PHARMACY STOCK -- Pharmacy stock is checked monthly for outdated or expiring medications. Pharmacy Staff are responsible to check their assigned pharmacy stock section monthly for outdated or expiring medications.

1. Threshold: N/A
2. Reported to: Currently not reported

B. SUPPLEMENTAL DRUG ROOM -- Medications used from supplemental drug room are reconciled daily. Expiration dates are checked monthly by assigned pharmacy staff.

1. Threshold: N/A
2. Reported to: Currently not reported

C. NARCOTIC CII COUNTS PHARMACY NARCOTIC SUPPLY – CII-V reconciliation is done daily for all items that have been dispensed or added to stock at the end of the shift and documented by the technician's initials next to the line item. An audit and reconciliation of CII stock is done monthly.

1. Threshold: 100%
2. Reported to: QIC (quarterly), Pharmacy staff

D. MEDICATION STORAGE REFRIGERATOR TEMP – Medication Refrigerators are checked twice daily by nursing staff. The medication refrigerators in the pharmacy are checked a minimum of twice daily during pharmacy operating hours. All medication storage refrigerators and freezers are monitored continuously via wireless monitoring system. The first check each morning will include a review of the "Daily Sensor Report/ 12Hr" report for the previous 24 hours or longer if the department is not open 7 days/week. At the beginning of each month, the designated department will print a "TempTrak Equipment QA / Performance Report" for the preceding month and file with the temperature log.

1. Threshold: 100%
2. Reported to: Results of nursing station refrigerators are reported monthly via DRR to head nurse and Director of Nursing. Results of Pharmacy refrigerator temperatures are reported quarterly to QIC (copy of report to Pharmacy staff).

E. EMERGENCY BOXES AND CRASH CARTS -- The emergency boxes and crash carts are checked monthly for completeness and freshness of stock. (or when box/cart has been opened)

1. Threshold: N/A
2. Reported to: P&T (monthly)

F. PHARMACY OMNICELL MEDICATION TRANSACTION AUDIT – Each month the omnicell transactions for 8 residents over a 5 day period is compared to the Medication Administration Record for accuracy in documentation.

1. Reported to: Results of activities are reported to nurse manager, nursing director, Medication Error Reduction Subcommittee, P&T (monthly), and QIC (quarterly, copy of report to pharmacy staff)

G. NURSING STATION CHECKS -- Nursing stations are checked on a monthly basis for Title 22 regulatory compliance with proper storage of meds, expiration dates, absence of discontinued medications, cleanliness, presence of appropriate drug information sources and applicable written hospital policies.

1. Threshold: N/A
2. Reported to: Nurse Manager, Director of Nursing & Hospital Administration (monthly) and P&T.

H. DRUG REGIMEN REVIEWS -- In accordance with State and Federal guidelines, the medical charts of all patients are reviewed every 30 days by a pharmacist (refer to Policy & Procedure 06.01.00).

1. Threshold: 100%
2. Reported to: Medication irregularities are reported in writing to the unit physician and nurse manager monthly. Copies of the reports are provided to Director of Medicine, Director of Nursing, Hospital Administration. Electronic copies are maintained in the Pharmacy Department.

I. MEDICATION PASS OBSERVATION – At least 4 units are selected per month for observation of medication administration.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (monthly), applicable nursing unit managers and nursing administration (monthly)

J. IV PREPARATION OBSERVATION AND STERILITY TESTING - Pharmacy personnel shall be observed during sterile compounding and evaluated at least annually ~~according to the Assessment of Aseptic Technique Evaluation Checklist~~ as part of competency assessments required to compound sterile ~~(~~preparations (refer to Policy & Procedure 07.01.00). ~~Products compounded during the annual evaluation shall be tested for sterility~~. Preparations compounded during the media fill challenge and gloved fingertip samples will be incubated per the manufacturer's specifications to test for microbial growth

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (Annually)

K. PHARMACY COMPOUNDING –~~At least one non-sterile and one sterile compounded item~~ At least one sterile preparation and one non-sterile preparation compounded by the pharmacy will be sent to an outside analytical laboratory for potency and sterility testing ~~quarterly~~annually. ~~The testing will include potency(non-sterile and sterile), sterility and presence of endotoxins for sterile compounded item.~~ See pharmacy policy and procedure 7.01.00 for details regarding retesting and recall for unacceptable results.

1. Threshold: Potency 100% +/- 10% actual concentration vs. labeled concentration; ~~Sterility and Endotoxin:100%.~~ No microbial growth 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (~~monthly~~Annually),

L. MEDICATION RECALLS -- Medications recalled by the FDA, ~~or by the~~ manufacturer, or at the discretion of the supervising pharmacist for a compounded preparation will be handled immediately upon notification. Recalled drugs are removed from stock as described in the Pharmacy Policy & Procedure for Drug Recall (02.04.00) and returned to wholesaler or manufacturer.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee and P&T, if recalled medication was in stock and nature of reason for recall poses potential risk or danger to residents

New: 10/91
Reviewed: 4/12, 8/13
Revised: 1/94SK, 3/98SK, 3/99DY, 6/99DY, 8/01DY, 10/03DW, 11/2010mf, 2011/06, 2014/11, 2015/10

07.00
STERILE PRODUCT PREPARATION, HANDLING AND DISPOSAL

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~~Hazardous Drug Risk Acknowledgement Form 13~~

Policy: The pharmacy shall ensure the sterility and integrity of sterile products prepared and used at Laguna Honda.
Purpose: To ensure the appropriate surveillance, prevention, and infection control procedures for sterile products.

Definitions and abbreviations

Beyond use date (BUD) - -the date or date and time, beyond which administration of a compounded drug product should not be begun, the product shall not be dispensed and the product shall not be stored (other than for quarantine purposes).~~used, stored, transported, or administered.~~

Primary engineering control (PEC) – a device that provides an ISO Class 5 or better environment through the use of unidirectional HEPA-filtered first air for the exposure of critical sites when compounding sterile preparations. Examples of PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, sterile compounding automated robots, compounding aseptic isolators, and compounding aseptic containment isolators.

Compounding aseptic isolator – a form of isolator specifically designed for **non-hazardous compounding** pharmaceutical ingredients or preparations while bathed with unidirectional air. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes

Compounding aseptic containment isolator (CACI) - a unidirectional compounding aseptic isolator (CAI) designed to provide worker protection from exposure **hazardous drugs** airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. The exhaust air from the isolator is removed by external building ventilation.

ISO- International Organization of Standardization (ISO) classification of particulate matter in room air. The number following ISO refers to air quality determined by the number of particles in a cubic meter of air. An ISO-5 environment level of quality must be maintained in the direct compounding area.

Direct Compounding Area (DCA) - Critical area within a primary engineering control exposed to unidirectional filtered air.

Isolator Gauntlet – A glove that is attached to the isolator sleeve intended for repeated use and changed at least monthly. Sterile gloves are donned over isolator gauntlets whenever engaged in compounding activities.

IV room – The designated area of positive pressure separate from routine work traffic that contains the primary engineering control (CAI) to compound non-hazardous sterile products. Refers specifically to room P2334 "IV PREP"

Hazardous drug room – The designated area of negative pressure separate from routine work traffic that contains the compounding aseptic containment isolator (CACI) used for compounding sterile and non-sterile hazardous drugs. Refers specifically to room P2332 "CHEMO PHARMACY"

Line of demarcation – A line on the floor marked with tape in both the IV and hazardous drug rooms that designates an ante-area for garbing towards the door separated from the clean working areas around the primary engineering control where personnel must be full gowned and garbed.

Qualified personnel – Pharmacists and pharmacy technicians that have completed required training and successfully passed all of the required competency assessments for sterile compounding

USP – United States Pharmacopoeia

RCRA – Resource Conservation and Recovery Act enacted in 1972 that governs the disposal of certain hazardous waste in the pharmacy.

CSP – Compounded sterile preparation

Pharmacy Areas for Preparing Sterile Products

1. Access to the IV room is limited to necessary/trained personnel.
2. Solutions, drugs, supplies and equipment used to prepare and administer sterile products shall be stored in accordance with manufacturer or USP requirements. Sterile products that require special storage conditions, for example, refrigeration and protection from light, shall be so stored. Refrigerator temperatures shall be ~~routinely documented~~wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
3. Outdated products should be removed from active storage areas.
4. Before each use, each drug, ingredient, and container should be visually inspected for damage, defects and expiration date.
5. Particle generating activities, such as removal of items from or manipulation of cardboard boxes, should be performed outside of the IV room and hazardous drug room.
6. Disposal of packing materials, used syringes, containers, and needles should be performed as needed.
7. ~~Sharps containers should be safely placed into the waste stream.~~ Waste shall be disposed of in the appropriate container of pharmaceutical (blue), trace hazardous waste (yellow), of bulk hazardous/RCRA designated waste (black).
7. Eating, drinking, and smoking are prohibited in the IV room and hazardous drug room.
8. Non-sterile to sterile "high risk" compounding shall not be performed by Laguna Honda Hospital Pharmacy

Hand Hygiene and Garbing procedure ~~Personal Protective Equipment and Scrubbing~~

1. Prior to entering hazardous drug room see policy and procedure 07.02.00 for additional garbing requirements specific to preparing, handling, and disposing of hazardous drugs
2. Prior to entering IV room or hazardous drug room inform a pharmacist of any change in eligibility to compound sterile preparations:
    a. Personnel with signs or symptoms of respiratory infection, exposed rashes, sunburn, conjunctivitis, fever, open wounds, or weeping sores shall be excluded from sterile compounding until condition is resolved.
    b. Any person wearing cosmetics, nail polish, or artificial nails shall not participate in sterile compounding. Fingernails should be kept clean and trimmed.
3. Remove any hand, wrist, finger, or other visible jewelry ~~Hand, finger, and wrist jewelry is removed.~~

~~1.~~4. Remove any neck lanyards, ties, or necklace jewelry

~~2. Fingernails should be kept clean and trimmed.~~

~~3. Dons hair cover, face mask, and shoe covers.~~ Don hair cover and face mask to cover bridge of nose down to the chin. Don additional facial hair cover if necessary.

5. Don shoe covers placing the first covered shoe over the line of demarcation to the clean side prior to donning the second shoe cover.

~~4.~~6. ~~Personnel should scrub their hands and forearms for at least 30 seconds using soap and warm water at the beginning of each aseptic compounding process and when reentering the controlled area.~~ Wash hands with soap and warm water up to the elbow scrubbing for at least 30 seconds and clean under nail bed with a clean nail pick whenever entering or re-entering the controlled area.

~~5. After drying hands and arms with lint-free towel, personnel will properly don appropriate protective gown.~~ Dry hands with a non-shedding disposable paper towel and don a non-shedding gown. A non-shedding blue splash resistant gown must be used in the hazardous drug compounding area. ~~ea.~~

7. Disinfect hands again using waterless ~~alcohol-based hand~~surgical scrub and allows hands to dry before placing hands in isolator gauntlets.~~sleeves/gloves~~

8. If working in the IV or hazardous drug room outside of the CAI or CACI then don gloves and disinfect with sterile 70% isopropyl alcohol making sure the elastic wrists of the gown covers the glove cuff. These gloves can be removed when hands are placed inside the isolator gauntlets to compound.

~~6.~~9. When using the compounding aseptic isolator sterile gloves must be donned over the isolator gauntlets prior to any compounding activities. When using the CACI in the hazardous drug room sterile gloves must be donned over isolator gauntlets prior to any compounding, cleaning, or decontamination activities.

~~7. Dispersion of the particles from body surfaces, such as from skin rashes or sunburns; increases the risk of contamination of critical sites and must be appropriately controlled or minimized. If severe, the operator must be excluded from the buffer or clean area until the condition is remedied, especially for high-risk operations.~~

10. At the end of aseptic compounding:
    a. Remove and discard gloves, facial hair cover, mask, and hair cover. All garb used in the hazardous drug room must be discarded to a yellow hazardous drug container.
    b. Remove and discard gown or hang on a hook on the clean side of the line of demarcation to be re-used by the same personnel during the same shift only. Re-used gowns must be discarded by the end of shift. Blue splash resistant gowns used for hazardous drug compounding may not be re-used under any circumstance.
    c. Perform hand hygiene with soap and water for at least 30 seconds
    d. Remove shoe covers one at a time ensuring that the uncovered foot is placed over the line of demarcation.
    e. Discard shoe covers and disinfect hands prior to leaving the compounding room.
    f. Ensure all garb is removed and discarded appropriately in the yellow hazardous drug waste bin prior to leaving the hazardous drug compounding area.

Environmental Controls

1. Engineering controls reduce the potential for airborne contamination in workspaces by limiting the amount and size of contaminants in the CSP processing environment
2. Primary engineering controls(PEC) at Laguna Honda Hospital Pharmacy include the compounding aseptic isolator (CAI) in the IV room and the compounding aseptic containment isolator (CACI) in the hazardous drug room.
    1. Isolator gauntlets shall be changed at least every month or whenever there is damage or a tear according to the manufacturer's directions and specifications.
    2. Isolator sleeves shell be changed every 6 months or whenever there is damage or a tear according to the manufacturer's directions and specifications
    3. Pre-filter shall be changed at least every 3 months according to the manufacturer's directions and specifications
3. Secondary engineering controls are used reduce airborne particles in the areas surrounding the primary engineering control and include:
    1. Separating the sterile compounding areas in rooms with a pressure differential relative to adjacent spaces (See next section for monitoring)
        i. IV room will be maintained at positive pressure
        ii. Hazardous drug room will be maintained at a negative pressure of at least -0.01 inches water column
    2. Rigorous cleaning program (described in environmental controls section 3)
    3. Standardized gowning, garbing, and hand hygiene procedure
    4. A line of demarcation to designate areas surrounding the primary engineering control that require qualified personnel to be fully gowned and garbed.
    5. Only the furniture, equipment, supplies, and other goods required for the tasks to be performed may be brought into this room, and they should be non-permeable, non-shedding, and resistant to disinfectants.
        i. Carts should be of stainless steel wire or sheet metal construction with good quality, cleanable casters to promote mobility.
        ii. Storage shelving counters, and cabinets should be smooth, impervious, free from cracks and crevices, non-shedding, cleanable, and sanitary. Their number, design, and manner of installation should promote effective cleaning and sanitizing.
    6. Maintaining an organized and uncluttered environment with minimal horizontal workspaces
    7. The surface of ceilings, walls, floors, fixtures, shelving, counters, and cabinets in the IV room are to be smooth, impervious, free from cracks and crevices, and non-shedding, thereby promoting clean ability and minimizing spaces in which microorganisms and other contaminants may accumulate. The surfaces should be resistant to damage by sanitizing agents.
    8. Items brought into the CAI or CACI are disinfected with sterile 70% isopropyl alcohol prior to transporting.

4. Sterile product preparation will be performed in a CAI or CACI that provides at least ISO 5 air quality.
    1. International Organization of Standardization (ISO) Classification of Particulate Matter in Room Air (Limits are in particles 0.5µm and larger per cubic meter (current ISO)

2. Engineering controls reduce the potential for airborne contamination in work spaces by limiting the amount and size of contaminants in the CSP processing environment.

A. Compounding Aseptic Isolators (CAI)

Engineering controls reduce the potential for airborne contamination in workspaces by limiting the amount and size of contaminants in the CSP processing environment. Primary engineering controls are used and include vertical flow biological safety cabinets and CAIs. International Organization of Standardization (ISO) Classification of Particulate Matter in Room Air (Limits are in particles 0.5μm and larger per cubic meter (current ISO)

Class Name		Particle Count	
ISO Class	US FS 209E	(ISO,m^3)	(FS 209E ft^3)
3	Class 1	35.2	1
4	Class 10	352	10
5	Class 100	3,520	100
6	Class 1000	35,200	1000
7	Class 10,000	352,000	10,000
8	Class 100,000	3,520,000	100,000

3. Sterile product preparation will be performed in a CAI environment to provide an adequate critical site environment.
4.2. CAI will provide at least ISO Class 5 air quality.
5. Only the furniture, equipment, supplies, and other goods required for the tasks to be performed may be brought into this room, and they should be non-permeable, non-shedding, and resistant to disinfectants.
6. Whenever items are brought into the CAI, they are to be cleaned and sanitized by spraying or wiping with 70% isopropyl alcohol prior to transporting.
7. The surface of ceilings, walls, floors, fixtures, shelving, counters, and cabinets in the IV room are to be smooth, impervious, free from cracks and crevices, and non-shedding, thereby promoting clean ability and minimizing spaces in which microorganisms and other contaminants may accumulate. The surfaces should be resistant to damage by sanitizing agents.
8. Carts should be of stainless steel wire or sheet metal construction with good quality, cleanable casters to promote mobility.
9. Storage shelving counters, and cabinets should be smooth, impervious, free from cracks and crevices, non-shedding, cleanable, and sanitary. Their number, design, and manner of installation should promote effective cleaning and sanitizing.

B. Testing/monitoring of Environmental Controls

Evaluation of environmental quality will be performed by measuring the number of viable microorganisms in the controlled air environments of the compounding area.

1. Pressure Differential Monitoring
   a. IV room and hazardous drug room relative to adjacent areas

1. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
2. If differential pressure becomes negative in the IV room or out of range in the hazardous drug room engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow or beyond use dating are necessary until the desired pressure differential is restored.

b. CAI and CACI
1. Checked daily by qualified personnel and recorded on "barrier isolator magnahelic pressure log"
2. The CAI and CACI will sound an audible alarm in the event that pressure differentials fall out of the manufacturer specified operation ranges. When the alarm is sounded the supervising pharmacist will be informed to evaluate and troubleshoot before any sterile compounding activities are continued and will determine if any compounded preparations made at the time of the alarm were compromised.

2. Temperature monitoring
   a. Refrigerator temperature in the IV room is wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
   b. The temperature of the IV room and hazardous drug room are continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for IV drugs.
3. Humidity gauges are present in the IV room and hazardous drug room to detect significant changes that would affect operator comfort.
4. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.
5. Certification will be performed by a qualified operator to meet test standards of CETA Certification Guide for Sterile Compounding Facilities under dynamic conditions to include viable and non-viable particle counts.
6. Viable particle counts
   a. Viable surface sampling is performed every six months in the primary engineering controls and the surrounding areas by an outside qualified operator as part of routine certification testing
   b. Viable particles in the air are tested by volumetric air sampling procedures by an outside qualified operator every six months as part of routine certification testing. Volumetric air sampling will test a sufficient volume of air (400 to 1,000 liters) at locations inside the PEC and surrounding area.

~~1. Particle count assessments~~
   ~~a. Certification that each CAI is functioning properly and meets air quality requirement of ISO Class 5 will be performed by a qualified operator(s) using current, state-of-art electronic air sampling at least every six months and whenever the CAI is relocated.~~

~~b. These records will be maintained and reviewed by the pharmacy manager or other designated staff member.~~

~~2. Evaluation of airborne microorganisms~~
~~Evaluation of airborne microorganisms in the CAI will be performed by a qualified operator(s) using current, state-of-art electronic air sampling at least every six months and whenever the CAI is relocated.~~

C. Cleaning and Sanitizing of the Workspaces

1. Procedure for cleaning of primary engineering controls
   a. The cleaning, sanitizing and organizing of the direct compounding areas (DCA) is the responsibility of ~~trained operators (Pharmacists and technicians)~~ qualified pharmacists and pharmacy technicians and is performed prior to any compounding activities and at least daily when the pharmacy is open. ~~Clean the DCA with isopropyl alcohol and low lint producing towel. Do not use paper towels or other high particulate materials to clean the hood.~~
   b. See hazardous drug policy for additional steps required for cleaning the hazardous drug compounding area.
   c. Sanitize the gauntlets of the CAI or CACI with a germicidal detergent and allow to dry.
   d. Disinfect the gauntlets of the CAI or CACI with ~~70%~~ sterile 70% isopropyl alcohol
   e. Replace the non-shedding pad on the isolator cleaning tool and utilize it during the following cleaning procedures to clean surfaces that would normally be out of reach.
   f. Sanitize all surfaces in the primary engineering control (including the gauntlets again) with a germicidal detergent to remove gross filth. A pre-saturated non-shedding wipe –or spray may be used with the isolator cleaning tool.
   ~~a.~~g. Do not use a spray bottle in the hazardous drug CACI because it can spread hazardous drug residues.
   ~~b. Make sure not to let any liquid pass into any of the open spaces in the hood. It can damage or contaminate the HEPA filters.~~ Do not directly spray the ceiling towards the HEPA filter because it can cause damage and compromise its integrity.
   ~~c. Use a side-to side motion, starting with the back, then the sides followed by the glass shield and finally the bottom of the work area.~~When cleaning surfaces use an overlapping horizontal motion in one direction starting at the top of the isolator working down. Clean the ceiling first, then the back, then the sides, and finally the bottom surface inside the primary engineering control. Be sure to clean the antechamber in addition to the direct compounding areas.
   h. After sanitizing with a germicidal detergent then disinfect the surfaces of the primary engineering control (including the gauntlets again) with sterile 70% isopropyl alcohol following the previous procedures.

i. Once a week replace the germicidal detergent with a sporicidal detergent for sanitizing all surfaces including the gauntlets in the primary engineering control.

j. When working in the hazard drug room use the 2 step deactivating wipes on all surfaces of the CACI including the gauntlets and the antechamber. The first wipe will deactivate potentially hazardous drug residues with sodium hypochlorite and the second wipe will prevent the sodium hypochlorite from damaging the surfaces of the CACI with thiosulfate.

k. Discard 2 step deactivation wipes in the yellow hazardous drug waste bin.

l. After completing the cleaning process, document the activity in the "Compounding Aseptic Isolator Cleaning Log" form.

d.m. Prior to donning sterile gloves and after the previous cleaning procedures sanitize the gauntlets of the CAI or CACI

n. If the primary engineering control CAI has been turned off between aseptic procedures, it should be operated for at least 30 minutes to allow complete purging of room air from the critical direct compounding area, then disinfected before work begins and periodically thereafter.cleaned with the above procedures before performing any compounding activities

o. Once a month the CAI will undergo a deep cleaning in which the front panel is opened and the bottom work tray is lifted out to clean area underneath working in a horizontal unidirectional motion from right to left starting from the back and working forward with overlapping strokes. The deep clean will consist of sanitizing with a sporicidal detergent and disinfecting with 70% sterile isopropyl alcohol.

e.p. The CACI will also undergo deep cleaning once a month as described above, but the front viewing panel will NOT be opened to minimize for potential exposure to hazardous drug residues.

2. Work surfaces near the DCA in the IV room are cleaned in a similar manner, including counter tops and supply carts. All ISO class 5 surfaces, work table surfaces, carts, counters, and floor shall be cleaned at least daily when the pharmacy is open using a germicidal detergent followed by disinfecting with sterile 70% isopropyl alcohol. Once a week the germicidal detergent shall be replaced with a sporicidal agent

3.2. Floors in the compounding areasIV rooms are sanitized and cleaned by mopping once daily when the pharmacy is open and when no aseptic operations are in progress. Mopping may be performed by trained and supervised custodial personnel using approved agents described in section 2 above. Only approved cleaning and sanitizing agents are used with careful consideration of compatibilities, effectiveness, and inappropriate or toxic residues. All cleaning tools, such as wipers, sponges, and mops, are non-shedding and dedicated a specific compounding area.

4. Walls and ceilings are sanitized with a germicidal detergent followed by disinfection with sterile 70% sterile isopropyl alcohol at least weekly and documented on the appropriate cleaning log cleaned with an appropriate sanitizer at least weekly.

5.3. Storage shelving is emptied of all supplies and sanitized with a germicidal detergent followed by disinfection with sterile 70% sterile isopropyl alcohol at least weekly and

documented on the appropriate cleaning logthen cleaned and sanitized at least weekly, using approved agents.

6.4. Trash is collected in suitable plastic bags and removed with minimal agitation. Pharmaceutical waste and hazardous drug/RCRA waste is collected when approximately two thirds full.

5. No shipping or other external cartons may be taken into the IV room.

7. Cardboard, shipping cartons, or high particle generating containers will NOT be brought into the IV room or hazardous drug room.

8. Supplies required for the scheduled operations are wiped down with sterile 70% isopropyl alcohol and brought into the CAI. Alternatively, when sterile supplies are received in sealed pouches designed to keep them sterile until opening, the sterile supplies may be removed as the supplies are introduced into the CAI without the need to sanitize the individual supply items.All supplies required for compounding and cleaning activities will be disinfected with 70% sterile alcohol prior to being introduced to the IV or hazardous drug room.

6. Supplies required for compounding are disinfected with sterile 70% isopropyl alcohol before being placed in the antechamber of a primary engineering control.

7.

Master Compounding Formula

1. Prior to any compounding activities a master formula approved by a pharmacist must be created or obtained from the library of master formulas stored on the pharmacy intranet.
2. A master formula must include the following:
    a. Active and inactive ingredients to be used
    b. Equipment to be used including the appropriate primary engineering control
    c. The maximum allowable beyond use date for the preparation, and the rationale or reference source justifying its determination
    d. Specific and essential compounding steps used to prepare the drug
    e. Quality reviews required at each step in the preparation of the drug including:
        i. Review calculations on master formula to confirm that the measurement of each additives and diluent will result in the final labeled concentration
        ii. Visual inspection of all ingredients to be used for manufacturer expiration dating and integrity of manufacturer packaging such as broken seals on vials or punctures in a stopper or injection port.
        iii. Visual inspection of any reconstituted products for complete dissolution
        iv. Visual inspection of any vial stopper or injection port punctured for evidence of leaking or coring.
        v. Pharmacist to verify volume or measurement of any additive prior to final dilution and confirm it matches the master formula.
        vi. Visual inspection after final dilution against a well-lit contrasting background to detect the presence of impurities such as particulate matter, unexpected change in color, precipitation, or coring.

f. Instructions for storage or special handling requirements

a.g. An "update log" section shall be included on every master formula to include the date of creation with pharmacist initials. Any modifications to an existing master formula shall be documented in the "update log" sections with the description of changes as well as the date and pharmacist initials.

Aseptic Technique and Pharmacy Sterile Product Preparation

Verify if any ingredients used in compounding are listed as hazardous and confirm with a pharmacist that the appropriate primary engineering control and compounding area are used for hazardous drugs.

1.

2. Sterile preparations shall be compounded in a primary engineering control that maintains an ISO class 5 environment under dynamic conditions using aseptic technique. Sterile products must be prepared with aseptic technique in a class 100 environment.

1. Aseptic technique refers to standardized compounding procedures intended to decrease the risk of contamination of a compounded sterile product.

2.3. Talking should be minimized during aseptic preparation.

3.4. Ingredients used to compound sterile products should be determined to be stable, compatible, and appropriate for the product to be prepared, according to manufacturer or USP guidelines or appropriate scientific references. Ingredients and compounding process for each preparation is determined in writing and reviewed by a pharmacist on a master formula before compounding begins.

5. All ingredients should be inspected for defects, expiration date, and product integrity before use. Expired or defective products should not be used for compounding. Defective products should be reported to the FDA Med Watch Program, https://www.accessdata.fda.gov/scripts/medwatch/, or 1-800-FDA-1088.

4.6. Prior to performing any activities in the primary engineering control inspect the isolator gauntlets and sleeves for any defects or tears.

5. Surfaces should be disinfected with 70% isopropyl alcohol before preparation of any product. Cleaning should be done on the innermost surface and advance toward the operator in a uniform line of movement, using a non-linting/non-particulate-generating cloth. Allow the surface to dry.

7. Outer wrappings of essential items for compounding should be removed before placement within the hood. The surfaces of ampoules, vials, and container closures should Any ingredient, equipment, or item required for sterile compounding shall be disinfected with sterile 70% isopropyl alcohol on all surfaces before placing inside the antechamberthem inside the hood.

8. Wait at least 10 seconds after placing items into the antechamber before opening the divider and bringing items into the work area inside the primary engineering control.

6.9. All rubber stoppers of vials and bottles, and the necks of ampoules, and injection ports into an IV bag are disinfected by wiping with sterile 70% isopropyl alcohol and waiting at least 10 seconds before they are used to prepare sterile products.

~~7.~~10. Only materials essential for preparing the sterile product should be placed in the primary engineering control~~CAI~~. Products must be adequately separated so as not to disrupt the unidirectional airflow leaving the high efficiency particulate air (HEPA) filter. Overcrowding of materials should be avoided also to minimize disruption of clean airflow.

~~8.~~11. Extreme care must be taken to prevent obstruction of clean air across the critical area or site, defined as the area immediate to the point of entry area in to a container, including the needle or device used to enter the container. The pharmacist or technician must be aware about the relation of other objects within the cabinet so that these objects never become an obstacle between the HEPA filter and critical area, as this can cause contamination of the critical area. Avoid reaching directly over the critical area because contaminants from the person or clothing may fall on the critical area. Only the cleanest air should be allowed to flow over the critical area of all the materials within the hood.

~~9.~~12. Avoid touch contamination of sterile needles, syringe parts, and other critical sites.

~~10.~~13. Solutions from ampoules must be properly filtered to remove particles.

~~11.~~14. Solutions from reconstituted powders should be mixed carefully, ensuring complete dissolution of the drug with the appropriate diluents.

~~12.~~15. Needle entry into vials should be performed at a 45-60° angle with the beveled side facing upwards to avoid coring of the vial closure.

~~13.~~16. After completion of the product, an additive cap or seal should be placed over the stopper or additive portal, to signify completion of the product as well as protect the portal from contamination.

~~14.~~17. Before, during and after the preparation of sterile products, the pharmacist or technician should carefully check the identity and verify the amounts and sequence of the additives in the sterile preparations detailed in the master drug formula against the original prescription, medication order, or other appropriate documentation before the product is released or dispensed.

~~15.~~18. After the preparation of every compounded sterile product, the contents of the container are thoroughly mixed and then inspected for the presence of particulate matter, evidence of incompatibility, or other defects.

~~16.~~19. After procedures are completed, used syringes, bottles, vials, and other supplies are removed, but with a minimum of exit and re-entry into the ~~DCA~~ direct compounding area so as to minimize the risk of introducing contamination into the aseptic workspace.

Beyond Use Dating

1. Shall be defined as the date beyond which the compounded drug product should not be used, stored, transported, or administered.

~~1. Opened or needle-punctured single-dose containers such as bags, bottles, syringes, and vials of sterile products shall be used within 1 hour.~~ Single dose vials or containers shall not be stored for re-use unless approved by the pharmacist in charge at the time of opening in which case it may be stored for not more than 1 hour in an ISO class 5 environment. Single dose vials or containers shall not be re-used under any circumstance if exposed to a non-ISO class 5 environment after opening.

2. Multiple-dose vials containing antimicrobial preservative may be used for up to 28 days after ~~initially entering~~ initial puncture or opening unless otherwise specified by the manufacturer.

3. ~~Beyond use dating of CSP will be assigned based on manufactures' product labeling or from appropriate literature sources.~~The rationale or reference source justifying the beyond use date of any compounded product shall be included on the master drug formula
4. The beyond use date of any compounded product shall not exceed those identified by California board of pharmacy regulation
5. The beyond use date of any compounded sterile product shall not exceed those identified in chapter 797 of the United States Pharmacopoeia.
6. ~~3.~~6. The beyond use date of any compounded non-sterile products shall not exceed those identified in chapter 795 of the United States Pharmacopoeia.

Qualifications of Personnel Who Prepare Sterile Products

1. ~~Personnel who prepare sterile products shall have training and demonstrated competence in the safe handling and compounding of parenteral solutions including cytotoxic agents.~~
1. ~~Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.~~
2. Qualified personnel that compound sterile products for patient use shall pass the following competency assessments at least annually.
    a. Hand hygiene (see attached assessment for details)
    b. Gowning and garbing (see attached assessment for details)
    c. Sterile compounding calculations exam
    d. Cleaning and disinfection of controlled compounding areas and equipment (see attached for details of criteria)
    e. Sterile compounding knowledge assessment
        i. Shall include review of most current policy and procedure
        ii. Contents to be determined and re-evaluated annually or more frequently at the discretion of the pharmacist in charge
    f. Gloved fingertip testing (see attached assessment for results recording and incubation process)
        i. Defined as a process whereby compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which are then incubated at a temperature and period of time conducive to multiplication of microorganisms as determined by the manufacturer.
        ii. Presence of any microbial growth shall require remediation and reassessment before personnel can continue to compound sterile products
        iii. Gloved fingertip testing shall be performed with sterile gloves donned over the gauntlets of the compounding aseptic isolator prior to a media fill challenge and after a media fill challenge for both the right and left hands.
        iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.

g. Media fill challenge (see attached assessment for results recording and incubation process)

i. Shall consist of compounding procedures using a growth based media to mimic the most complex procedures performed by the pharmacy.

ii. The design of the media fill challenge shall be recorded in the IV competency binder located in the clinical pharmacist office and available on the pharmacy intranet.

iii. The design of the media fill challenge shall be re-assessed at least annually and any modifications recorded along with rationale.

iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.

h. Hazardous drug compounding assessment as defined in hazardous drug policy

3. New personnel shall be oriented with the policy and procedure of compounding sterile products and receive adequate training consisting of audio/visual materials, shadowing a qualified compounder, and hands on practice under the supervision of a qualified compounder prior to initial competency assessment. The pharmacist in charge shall determine when new personnel have completed adequate training to begin competency assessment.

4. New personnel shall complete gloved fingertip assessments on 3 separate occasions prior to compounding sterile products for patient use.

5. Records of competency assessment shall be available for each individual qualified personnel and retained for three years.

2.

Quality Assurance

1. Proper aseptic technique shall be utilized in the preparation of intravenous solutions. Sterility and proper preparation technique shall be assured through random sampling and testing by the Department of Pharmaceutical Services.

2. The aseptic technique of each individual must be evaluated using the Assessment of Aseptic Technique Evaluation Checklist, Appendix 1.

3. If growth is detected, the entire preparation process must be evaluated, corrective action taken, and the testing performed again.

All personnel must be revalidated annually, whenever the quality assurance program yields an unacceptable result, and whenever unacceptable techniques are observed; this revalidation must be documented.

1. To ensure continued standardization of procedures any changes made to the pharmacy policy and procedure on compounding of sterile or hazardous preparations will be communicated to all qualified personnel via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.

2. Qualified personnel shall not participate in sterile compounding activities until reviewing all changes to policy and procedure via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.

3. End product testing for sterility and potency for a single compounded sterile product shall be conducted at least annually and repeated upon receipt of any unacceptable results.

   a. If end product sterility testing results in microbial growth the supervising pharmacist will recall all sterile preparations from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).

   b. If end product potency testing results in greater than 10% variability of actual concentration vs. labeled concentration the supervising pharmacist will recall all compounded products from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).

4. Quality of aseptic technique for each personnel will be assessed by directly observed media fill challenge at least annually, whenever unacceptable technique is observed, or when end product sterility testing yields microbial growth.

5. Standards aseptic technique are described in the above policy and procedure

6. Action levels for colony-forming units (CFUs) detected during quality assurance activities:

Classification	Volumetric air sample	Fingertip sample	Surface sample
ISO Class 5	>1	Zero	>3
ISO Class 8	>100	N/A	>100

a. When action levels are exceeded during fingertip sampling the employee shall not compound sterile products until remediation and successful resampling

b. When action levels are exceeded during environmental sampling the pharmacy shall investigate the possible sources of contamination and document interventions along with results of resampling. The beyond use dating of sterile products compounded prior to successful resampling shall be evaluated and potentially adjusted as determined by the pharmacist-in-charge.

c. When action levels are exceeded during surface sampling or volumetric air sampling the colony-forming units will be sent for identification to at least the genus level.

~~**Preparation, Handling and Disposal of Hazardous Drugs**~~

1. ~~The pharmacy will prepare, handle and discard cytotoxic agents, which include all chemotherapy products, in a manner which ensures aseptic preparation, employee protection from exposure, and safe handling of finished products and disposal of materials or waste products.~~

2. ~~Pharmacy practices will meet or exceed the standards set by the Occupational Safety and Health Administration (OSHA), and the Guidelines adopted by the American Society of Hospital Pharmacists (ASHP). Cytotoxic agents are known or suspected carcinogens. Many of these agents are chemotherapy medications used to treat cancer. Proper handling and the use of protective wear reduces the risk of exposure to these agents to individuals preparing or administering chemotherapy products~~

3. ~~Handling~~
    a. ~~Hazardous drugs shall be handled with caution at all times using chemotherapy gloves during receiving, distribution, stocking, inventorying, preparation for administration and disposal.~~
    b. ~~Pharmacy staff will be in serviced annually regarding the precautions related to handling these agents.~~
    c. ~~Spill kits will be placed in the IV room, pharmacy and nursing stations where cytotoxic agents are administered.~~
    d. ~~Staff involved in handling of hazardous drugs shall complete a hazardous drug risk acknowledgement form annually (Appendix 2).~~
4. ~~Storage~~
    a. ~~Chemotherapy products will be stored in the pharmacy in a separate chemotherapy shelving area, in alphabetical order by generic name.~~
        i. ~~Chemotherapy products requiring refrigeration will be stored on a separate shelf in the pharmacy refrigerator.~~
    b. ~~Products will be reviewed routinely to assure expired medications are not dispensed.~~
5. ~~Order Processing~~
    a. ~~Order Review~~
        i. ~~A pharmacist will review each chemotherapy order before preparation to ensure appropriateness, including dose, route, indication, compatibility, conflict with the resident's allergies, and legibility.~~
        ii. ~~The pharmacist will contact the prescriber if any inappropriate or unclear information is present.~~
        iii. ~~The product will not be prepared until the order is clarified, if clarification is needed.~~
    b. ~~Label Preparation~~
        i. ~~A label will be prepared for each chemotherapy product to include information as specified in Labeling Policy.~~
        ii. ~~An auxiliary label, "CAUTION – CHEMOTHERAPY: HANDLE WITH GLOVES, DISPOSE OF PROPERLY" will be placed on the label of each chemotherapy product.~~
    c. ~~Product Preparation~~
        i. ~~All compounded chemotherapy products will be prepared in a negative pressure CAI.~~
        ii. ~~Only a pharmacist or a chemotherapy-certified technician may prepare compounded chemotherapy products.~~
        iii. ~~The pharmacist or technician will review the order and verify the accuracy of the label.~~

iv. ~~The pharmacist or technician will ensure that the negative pressure CAI is cleaned thoroughly before beginning preparation of a single or a series of products according to procedure outlined above.~~

d. ~~The pharmacist or technician will assemble all needed materials prior to beginning preparation in the negative pressure CAI.~~

e. ~~The pharmacist or technician will wear a disposable gown and disposable gloves to prepare all compounded chemotherapy. Gowns and gloves are available in different sizes and are stored in the IV room. Staff may choose to double glove when preparing hazardous agents.~~

f. ~~Using proper aseptic technique, the pharmacist or technician will prepare the product.~~

g. ~~The final product will be inspected for particulate matter. If found, the product shall be discarded and a new product prepared.~~

h. ~~For products compounded at LH, the pharmacist or technician will label the finished product, ensuring that the solution name printed on the final container is visible, if possible.~~

i. ~~For products compounded at LH, a pharmacist must verify the accuracy and appropriateness of all products made before the product is released for delivery to the resident care area. The pharmacist will initial the label after verification.~~

j. ~~Each chemotherapy product will be placed in a resealable plastic bag.~~

k. ~~The pharmacist or technician will remove his or her gloves and wash hands again after working with chemotherapy agents.~~

6. ~~Product Delivery~~

   a. ~~Chemotherapy products will be delivered to the nursing station where they are to be administered.~~

7. ~~Disposal~~

   a. ~~All materials used in the preparation of chemotherapy products will be placed in a designated leak-proof chemotherapy container.~~

      i. ~~A designated chemotherapy container will be kept adjacent to the CAI. Items will be placed in a plastic bag and placed directly into the container.~~

      ii. ~~Needles will be placed in a puncture-proof sharps container. Full sharps containers may be placed in the chemotherapy container for disposal.~~

   b. ~~Staff shall use a new container when the current container reaches ¾ full or 90 days from first use, whichever comes first. Notify environmental services when containers are ¾ full or after 90 days from first use.~~

~~Spill Management of Hazardous Drugs (HDs)~~

1. ~~A spill kit will be provided to areas where cytotoxic agents are stored, transported, prepared and administered. The spill kit is provided for safety reasons. The kit contains a protective gown, latex gloves, a mask and goggles, towels and spill control pillows, a scoop and brush, disposal bags and biohazard labels. These items will be used to clean an area contaminated by a cytotoxic substance.~~

2. ~~In case of spill or exposure to the cytotoxic substance, the following steps should be followed:~~

~~Spills are contained by the first competent staff person on the scene using the Cytotoxic Drug Spill kit maintained on Positive Care Units, Pharmacy, Supplemental Drug Room and CSR.~~

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

~~**For spills greater than 5 ml**, use personal protective equipment provided in the Spill Kit.~~

~~(1) Caution bystanders to avoid the spill and immediately obtain the spill kit from the treatment room.~~
~~(1) Open the kit. Use chemo spill caution sign to mark spill area.~~
~~(2) Place spill pillows in a "V "position on the outer perimeter of spill to prevent spread.~~
~~(3) Put on chemotherapy gown, N95 respirator mask, shoe covers chemical splash goggles and double chemotherapy gloves. Open the plastic chemo waste disposal bags.~~
~~(4) Place absorbent towels over spill, being careful not to touch the spill.~~
~~(5) Pick up saturated towels and spill pillows and place in small chemo waste bag. Use disposable scoop and brush as needed to pick up debris.~~
~~(6) Place filled small chemo waste bag into spill kit box and seal the box with the chemo waste label.~~
~~(7) Discard chemo spill kit box and outer gloves into large chemo waste bag.~~
~~(8) Remove mask, goggles, gown and inner gloves and dispose of in large chemo waste bag.~~
~~(10)Seal the bag and dispose of in the cytotoxic waste container.~~
~~(11)Notify Environmental Services for a final mop-down according to EVS procedures.~~
~~(12)Report the spill to the Industrial Hygienist.~~
~~(13)Complete a Confidential Report of Unusual Occurrence.~~

Labeling

1. Finished products should be labeled with at least the following information:
   - Resident's name
   - Prescription number
   - Patient or medical record number
   - Directions including rate of administration for IV medications
   - Name & concentration of all ingredients (including primary solution)
   - Prescribing physician's name
   - Date filled
   - Expiration date
   - Pharmacist's, technician's initials
   - Pharmacy telephone number
   - Instructions for storage & handling
   - All cytotoxic agents shall bear a special label stating: "Chemotherapy – Handle with gloves, Dispose of Properly"

2. The label should be legible and affixed to the final container in a manner enabling it to be read while the sterile product is being administered.

End Product Evaluation

1. The final product should be inspected when preparation is completed and again when the product is dispensed. This inspection includes an evaluation for container leaks, container integrity, solution cloudiness or phase separation, particulates in the solution, appropriate solution color, and solution volume.

2. The pharmacist shall verify that the product was compounded accurately with the correct ingredients, quantities of each ingredient, containers, and reservoirs.

Handling of Sterile Products Outside the Pharmacy

1. Sterile products should be transported in a manner to protect the medication from extremes of temperature outside their range of stability and from light if they are photosensitive.
2. Delivery personnel should be instructed on special handling procedures.
3. Once delivered to the end user, sterile products should be appropriately stored before use.
4. Special instructions for storage shall be a part of the label or separate information sheet.
5. Sterile products that display evidence of contamination or instability, or are improperly labeled shall be returned to the pharmacy for disposition,
6. Pharmacists shall participate in training end users on the proper care and storage of sterile products, either directly or through written instructions.

Administration of Sterile Products

1. Medications will be competently and safely administered. The Nursing Service is responsible for the safe administration of sterile products. See LH Nursing Policies & Procedures: J 1.0-10.0 on Medication Administration.

Documentation and Recordkeeping

1. The following should be documented and maintained on file for an adequate period of time, according to organizational policies and state regulatory requirements:
   a. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.
   b. Refrigerator and freezer temperatures,
   c. Certification of CAI and CACI.
2. A record of medications dispensed shall be made in the resident's medication file. (See LH Pharmaceutical Services Policy 02.01.00: P& P for Distribution of Medications and Medication Order Processing.) In addition, the following information relevant to parenteral therapy shall be maintained:
   a. Resident's name, age, and sex,
   b. Diagnosis related to prescribed therapy,
   c. Relevant medication history, and
   d. Relevant laboratory data.

New 08/03
Revised 06/07dw, 01/08, 04/09, 2/10, 10/10, 08/11, 5/14
Reviewed: 3/2013, 8/15

Assessment of Hand Hygiene and Garbing of Compounding Personnel

Name: ____________________ **Date:**

Date of last assessment evaluation:

Before performing any aseptic compounding:

_______ Presents in a clean appropriate attire and manner
_______ Wears no jewelry (watches, rings, earrings, etc) upon entry into ante-areas
_______ Brings no food or drinks into or stored in the ante-areas or buffer areas
_______ Is aware of the line of demarcation separating clean and dirty sides
_______ Dons hair cover
_______ Dons face mask to cover bridge of nose down to include chin
_______ Dons shoe covers placing the covered or designated shoe on clean side of the line of demarcation, as appropriate
_______ Performs hand hygiene procedure by wetting hands and forearms and washing using soap and warm water for at least 30 seconds
_______ Dries hands and forearms using lint-free towel or hand dryer
_______ Selects the appropriate sized gown examining for any holes, tears, or other defects.
_______ Dons gown and ensures full closure
_______ Disinfects hands again using a waterless alcohol-based hand scrub and allows hands to dry thoroughly before placing hands in sleeves/gloves
_______ Dons appropriate sized sterile gloves ensuring that there is a tight fit with no excess glove material at the fingertips
_______ Examines gloves ensuring that there are no defects, holes, or tears
_______ Disinfects sterile gloves with sterile 70% isopropyl alcohol prior to work in the direct compounding area (DCA) and after touching items or surfaces that may contaminate gloves

At the end of aseptic compounding:

_______ Performs hand hygiene
_______ Removes gown and discards it, or hangs it on hook if it is to be reused within the same work day.
_______ Removes and discards hair cover
_______ Removes shoe covers one at a time, ensuring that uncovered foot is placed on the dirty side of the line of demarcation and performs hand hygiene again. (Removes and discards shoe covers every time the compounding area is exited)

Gloved Fingertip Sampling:

Q.I. Medical, Inc, Enviro Test Media Paddles, #ET1000 Lot # __________ Exp date: ___________
Start of incubation, date, time: ______________
Stop of incubation, date, time: ______________

	Left Hand	**Right Hand**
After handing hygiene and garbing:	Growth / No Growth	Growth / No Growth
After completing media-fill preparation:	Growth / No Growth	Growth / No Growth

____

Signature of Person Assessed Printed Name Date

Signature of Qualified Evaluator Printed Name Date

*The person assessed is immediately informed of all unacceptable activities, and shown and informed of specific corrections.

Assessment of Aseptic Technique of Compounding Personnel

Name: ______________________ **Date:** __________

Compounding Aseptic Isolator:

_______ Understands theory of operation
_______ Identifies main hood components
_______ Understands gauges
_______ Knowledge of maintenance procedures
_______ When to clean
_______ Order of cleaning
_______ Method of cleaning

Observed Technique:

_______ Completes the Hand Hygiene and Garbing Competency Assessment Form
_______ Disinfects ISO Class 5 device surfaces with an appropriate agent
_______ Disinfects components/vials/supplies with an appropriate agent prior to placing into compounding aseptic isolator (CAI)
_______ Introduces only essential materials in a proper arrangement in the CAI
_______ Does not interrupt, impede, or divert flow of first-air to critical sites
_______ Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in ISO Class 5 work area
_______ Performs manipulations only in the appropriate direct compounding area (DCA) of the CAI.
_______ Does not expose critical sites to contact contamination or worse than ISO Class 5 air
_______ Disinfects stoppers, injection ports, and ampule necks by wiping with sterile 70% IPA and allows sufficient time to dry
_______ Work zone is free from clutter, debris, and spilled drug
_______ Affixes needles to syringes without contact contamination
_______ Punctures vial stoppers and spikes infusion ports without contact contamination
_______ Aseptically transfer from vial to IV container/bag
_______ Minimize unnecessary talking or laughing
_______ Labels preparation(s) correctly.
_______ Disinfects sterile gloves routinely by wiping with sterile 70% IPA during prolonged compounding manipulations
_______ Disposes of sharps and waste according to institutional policy or recognized guidelines
_______ Proper clean-up and disinfection of CAI

Media Fill Test:

Q.I. Medical, Inc, GroMed TSB Growth Media 100ml Lot # ______________ Exp date: ____________
Q.I. Medical, Inc, GroMed Media #GM0200 Lot # ______________ Exp date: ____________

Media Sample no.: __________________ Observed Colonization:

Start of incubation, date, time: _______________ Growth / No Growth
Stop of incubation, date, time: _______________

Signature of Person Assessed Printed Name Date

Signature of Qualified Evaluator Printed Name Date

Laguna Honda Hospital Department of Pharmacy

Assessment of Hand Hygiene and Garbing of Compounding Personnel

Name: ________________________________ **Date:**

Before Performing Any Aseptic Compounding:

_______ Presents in a clean appropriate attire and manner
_______ Wears no jewelry (watches, rings, earrings, etc) upon entry into ante-areas
_______ Brings no cell phone, food, or drinks into or stored in the ante-areas or buffer areas
_______ Is aware of the line of demarcation separating clean and dirty sides
_______ Dons hair cover
_______ Dons face mask to cover bridge of nose down to include chin.
_______ Dons beard cover over mask to cover any exposed facial hair if applicable
_______ Dons shoe covers placing the covered or designated shoe on clean side of the line of demarcation, as appropriate
_______ Performs hand hygiene procedure by wetting hands and forearms and washing using soap and warm water for at least 30 seconds and uses a nail pick to clean under nail beds while washing.
_______ Dries hands and forearms using lint-free towel or hand dryer
_______ Selects the appropriate sized gown examining for any holes, tears, or other defects.
_______ Dons gown and ensures full closure
_______ Disinfects hands again using a waterless surgical hand scrub and allows hands to dry thoroughly before placing hands in isolator sleeves/gloves
_______ Dons appropriate sized sterile gloves ensuring that there is a tight fit with no excess glove material at the fingertips over gauntlets in containment aseptic isolator
_______ Examines gloves and isolator sleeves ensuring that there are no defects, holes, or tears
_______ Disinfects sterile gloves with sterile 70% isopropyl alcohol prior to work in the direct compounding area (DCA) and after touching items or surfaces that may contaminate gloves

At The End of Aseptic Compounding:

_______ Performs hand hygiene
_______ Removes gown and discards it, or hangs it on hook if it is to be reused within the same work day.
_______ Removes and discards hair cover
_______ Removes shoe covers one at a time, ensuring that uncovered foot is placed on the dirty side of the line of demarcation and performs hand hygiene again. (Removes and discards shoe covers every time the compounding area is exited)

Gloved Fingertip Sampling										
Tryptic Soy Agar – Bacteria (**TSA**)				Malt Agar Yeast Extract – Fungus (**MEA**)						
Q.I. Medical, Inc, EnviroTest Media Paddles, #ET1000 (**Red Top**) Incubate 2 to 3 days				Q.I. Medical, Inc, EnviroTest Media Paddles, #ET3000 (**Yellow Top**) Incubate 5 to 7 days						
Lot # ____________ Exp date: ____________				Lot # ____________ Exp date: ____________						
Start incubation date/time:		**Stop** incubation date/time:		**Start** incubation date/time:			**Stop** incubation date/time:			
Results				**Daily Inspection of Media**						
				1	**2**	**3**	**4**	**5**	**6**	**7**
Media	**Hand**	**Initials of Evaluator→**								
		Incubator Temp (Celsius)→								
TSA	Left	After hand hygiene and garbing								
TSA	Right	After media-fill preparation								
MEA	Left	After hand hygiene and garbing								
MEA	Right	After media-fill preparation								

(“- “ for no growth or “+” for growth, cloudiness, turbidity or “x” for pharmacy closed)

*The person assessed is immediately informed of all unacceptable activities, and shown and informed of specific corrections.

Laguna Honda Hospital Department of Pharmacy

Assessment of Aseptic Technique of Compounding Personnel

Name: ______________________________ **Date:** __________

Compounding Aseptic Isolator:

_______ Understands theory of operation
_______ Identifies main hood components
_______ Understands pressure gauges and importance of positive/negative air pressure in CAI
_______ Knowledge of maintenance procedures
_______ Identifies how often primary and secondary engineering controls must be cleaned
_______ Identifies how often isolator gloves, sleeves, and filters must be changed

Observed Technique:

_______ Completes the Hand Hygiene and Garbing Competency Assessment Form
_______ Disinfects ISO Class 5 device surfaces with an appropriate agent
_______ Disinfects components/vials/supplies with an appropriate agent prior to placing into the ante chamber of the compounding aseptic isolator (CAI)
_______ Wait at least 10 seconds before bringing compounding elements from ante chamber into work area
_______ Introduces only essential materials in a proper arrangement in the CAI
_______ Does not interrupt, impede, or divert flow of first-air to critical sites
_______ Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in ISO Class 5 work area
_______ Performs manipulations only in the appropriate direct compounding area (DCA) of the CAI.
_______ Does not expose critical sites to contact contamination or worse than ISO Class 5 air
_______ Disinfects stoppers, injection ports, and ampule necks by wiping with sterile 70% IPA and allows sufficient time to dry
_______ Work zone is free from clutter, debris, and spilled drug
_______ Affixes needles to syringes without contact contamination
_______ Punctures vial stoppers and spikes infusion ports without contact contamination
_______ Aseptically transfer from vial to IV container/bag
_______ Minimize unnecessary talking or laughing
_______ Labels preparation(s) correctly.
_______ Disinfects sterile gloves routinely by wiping with sterile 70% IPA during prolonged compounding manipulations
_______ Disposes of sharps and waste according to institutional policy or recognized guidelines
_______ Proper clean-up and disinfection of CAI

<table>
<tr><th colspan="15">**Media Fill Challenge** (incubate for 14 days)</th></tr>
<tr><td>Q.I. Medical, Inc, GroMed TSB Growth Media 100ml</td><td colspan="7">Lot #</td><td colspan="7">Exp. Date:</td></tr>
<tr><td>Q.I. Medical, Inc, GroMed Media #GM0200 20ml</td><td colspan="7">Lot #</td><td colspan="7">Exp. Date:</td></tr>
<tr><td>Q.I. Medical, Inc, Sterile Vial #EV0200 20ml</td><td colspan="7">Lot #</td><td colspan="7">Exp. Date:</td></tr>
<tr><td rowspan="2">**Results**</td><td colspan="7">**Start** incubation date/time</td><td colspan="7">**Stop** incubation date/time</td></tr>
<tr><td colspan="7"></td><td colspan="7"></td></tr>
<tr><td>**Daily Inspection of Media→**</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td></tr>
<tr><td>Initials of Evaluator</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Incubator temp (Celsius)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Growth</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

(“- “ for no growth or “+” for growth, cloudiness, turbidity)

~~San Francisco, CA 94116~~

~~Hazardous Drug Risk Acknowledgement Form~~

~~Health care personnel involved with the preparation, handling, administration, transportation and disposal of hazardous drugs may be at an increased health risk, with exposure occurring through inhalation of drug dusts or aerosols, skin absorption and inadvertent ingestion through contact with contaminated food or cigarettes, and needle stick injuries. Aerosols of hazardous drugs can result in exposing not only the worker immediately involved, but also exposing other people in the surrounding areas. Workers may also be exposed to hazardous drugs when they handle contaminated equipment and supplies. The risks to workers handling hazardous drugs are a combined result of the drugs' inherent toxicity and the extent to which workers are directly exposed. Other factors include the susceptibility of the individual to the drugs' toxic effects, and co-factors such as dietary habits, smoking, and man-made or natural environmental contaminants.~~

~~The effects of these drugs can be acute or delayed. The acute effects of these drugs include, but are not limited to irritation of the skin, eyes and mucous membranes. Headaches, lightheadedness, dizziness and nausea have also been reported. The delayed effects can include mutagenicity, teratogenicity, and carcinogenicity. Those of reproductive age should understand that there may be a relationship between occupational exposure and reproductive outcomes, including miscarriage, birth defects and low birth weight.~~

~~Staff who are trying to conceive (male or female), are pregnant or breast-feeding, should not handle cytotoxic or hormonal agents labeled/classified as Hazardous Drugs. Staff who fit into the above categories shall inform their immediate supervisor for work reassignment.~~

~~I have read the above statement and understand the possible health risk involved with occupational exposure to hazardous drugs.~~

____________________________________ __________________

~~Employee Name (Print)~~ ~~Date~~

____

~~Employee Signature~~

07.02.00
PREPARATION, HANDLING AND DISPOSAL OF HAZARDOUS DRUGS

Preparation, Handling and Disposal of Hazardous Drugs

1. The pharmacy will prepare, handle and discard cytotoxic agents, which include all chemotherapy products, in a manner which ensures aseptic preparation, employee protection from exposure, and safe handling of finished products and disposal of materials or waste products.
2. Pharmacy practices will meet or exceed the standards set by the Occupational Safety and Health Administration (OSHA), and the Guidelines adopted by the American Society of Hospital Pharmacists (ASHP). Cytotoxic agents are known or suspected carcinogens. Many of these agents are chemotherapy medications used to treat cancer. Proper handling and the use of protective wear reduces the risk of exposure to these agents to individuals preparing or administering chemotherapy products
3. Handling
    a. Hazardous drugs shall be handled with caution at all times using chemotherapy gloves during receiving, distribution, stocking, inventorying, preparation for administration and disposal.
    b. Pharmacy staff will be in serviced annually regarding the precautions related to handling these agents.
    c. Spill kits will be placed in the IV room, pharmacy and nursing stations where cytotoxic agents are administered.
    d. Staff involved in handling of hazardous drugs shall complete a hazardous drug risk acknowledgement form annually (Appendix 2).
4. Storage
    a. Chemotherapy products will be stored in the pharmacy in a separate chemotherapy shelving area, in alphabetical order by generic name.
        i. Chemotherapy products requiring refrigeration will be stored on a separate shelf in the pharmacy refrigerator.
    b. Products will be reviewed routinely to assure expired medications are not dispensed.
5. Order Processing
    a. Order Review
        i. A pharmacist will review each chemotherapy order before preparation to ensure appropriateness, including dose, route, indication, compatibility, conflict with the resident's allergies, and legibility.
        ii. The pharmacist will contact the prescriber if any inappropriate or unclear information is present.
        iii. The product will not be prepared until the order is clarified, if clarification is needed.

b. Label Preparation

i. A label will be prepared for each chemotherapy product to include information as specified in Labeling Policy.

ii. An auxiliary label, "CAUTION – CHEMOTHERAPY: HANDLE WITH GLOVES, DISPOSE OF PROPERLY" will be placed on the label of each chemotherapy product.

c. Product Preparation

i. All compounded chemotherapy products will be prepared in a negative pressure CAI.

ii. Only a pharmacist or a chemotherapy-certified technician may prepare compounded chemotherapy products.

iii. The pharmacist or technician will review the order and verify the accuracy of the label.

iv. The pharmacist or technician will ensure that the negative pressure CAI is cleaned thoroughly before beginning preparation of a single or a series of products according to procedure outlined above.

d. The pharmacist or technician will assemble all needed materials prior to beginning preparation in the negative pressure CAI.

e. The pharmacist or technician will wear a disposable gown and disposable gloves to prepare all compounded chemotherapy. Gowns and gloves are available in different sizes and are stored in the IV room. Staff may choose to double glove when preparing hazardous agents.

f. Using proper aseptic technique, the pharmacist or technician will prepare the product.

g. The final product will be inspected for particulate matter. If found, the product shall be discarded and a new product prepared.

h. For products compounded at LH, the pharmacist or technician will label the finished product, ensuring that the solution name printed on the final container is visible, if possible.

i. For products compounded at LH, a pharmacist must verify the accuracy and appropriateness of all products made before the product is released for delivery to the resident care area. The pharmacist will initial the label after verification.

j. Each chemotherapy product will be placed in a resealable plastic bag.

k. The pharmacist or technician will remove his or her gloves and wash hands again after working with chemotherapy agents.

6. Product Delivery

a. Chemotherapy products will be delivered to the nursing station where they are to be administered.

7. Disposal

a. All materials used in the preparation of chemotherapy products will be placed in a designated leak-proof chemotherapy container.

   i. A designated chemotherapy container will be kept adjacent to the CAI. Items will be placed in a plastic bag and placed directly into the container.

   ii. Needles will be placed in a puncture-proof sharps container. Full sharps containers may be placed in the chemotherapy container for disposal.

b. Staff shall use a new container when the current container reaches ¾ full or 90 days from first use, whichever comes first. Notify environmental services when containers are ¾ full or after 90 days from first use.

Spill Management of Hazardous Drugs (HDs)

1. A spill kit will be provided to areas where cytotoxic agents are stored, transported, prepared and administered. The spill kit is provided for safety reasons. The kit contains a protective gown, latex gloves, a mask and goggles, towels and spill control pillows, a scoop and brush, disposal bags and biohazard labels. These items will be used to clean an area contaminated by a cytotoxic substance.

2. In case of spill or exposure to the cytotoxic substance, the following steps should be followed:

   Spills are contained by the first competent staff person on the scene using the Cytotoxic Drug Spill kit maintained on Positive Care Units, Pharmacy, Supplemental Drug Room and CSR.

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

   For spills greater than 5 ml, use personal protective equipment provided in the Spill Kit.

   (1) Caution bystanders to avoid the spill and immediately obtain the spill kit from the treatment room.
   (1) Open the kit. Use chemo spill caution sign to mark spill area.
   (2) Place spill pillows in a "V "position on the outer perimeter of spill to prevent spread.
   (3) Put on chemotherapy gown, N95 respirator mask, shoe covers chemical splash goggles and double chemotherapy gloves. Open the plastic chemo waste disposal bags.
   (4) Place absorbent towels over spill, being careful not to touch the spill.
   (5) Pick up saturated towels and spill pillows and place in small chemo waste bag. Use disposable scoop and brush as needed to pick up debris.
   (6) Place filled small chemo waste bag into spill kit box and seal the box with the chemo waste label.
   (7) Discard chemo spill kit box and outer gloves into large chemo waste bag.
   (8) Remove mask, goggles, gown and inner gloves and dispose of in large chemo waste bag.
   (10)Seal the bag and dispose of in the cytotoxic waste container.
   (11)Notify Environmental Services for a final mop-down according to EVS procedures.
   (12)Report the spill to the Industrial Hygienist.
   (13)Complete a Confidential Report of Unusual Occurrence.

New 2015/10

Hazardous Drug Risk Acknowledgement Form

Health care personnel involved with the preparation, handling, administration, transportation and disposal of hazardous drugs may be at an increased health risk, with exposure occurring through inhalation of drug dusts or aerosols, skin absorption and inadvertent ingestion through contact with contaminated food or cigarettes, and needle stick injuries. Aerosols of hazardous drugs can result in exposing not only the worker immediately involved, but also exposing other people in the surrounding areas. Workers may also be exposed to hazardous drugs when they handle contaminated equipment and supplies. The risks to workers handling hazardous drugs are a combined result of the drugs' inherent toxicity and the extent to which workers are directly exposed. Other factors include the susceptibility of the individual to the drugs' toxic effects, and co-factors such as dietary habits, smoking, and man-made or natural environmental contaminants.

The effects of these drugs can be acute or delayed. The acute effects of these drugs include, but are not limited to irritation of the skin, eyes and mucous membranes. Headaches, lightheadedness, dizziness and nausea have also been reported. The delayed effects can include mutagenicity, teratogenicity, and carcinogenicity. Those of reproductive age should understand that there may be a relationship between occupational exposure and reproductive outcomes, including miscarriage, birth defects and low birth weight.

Staff who are trying to conceive (male or female), are pregnant or breast-feeding, should not handle cytotoxic or hormonal agents labeled/classified as Hazardous Drugs. Staff who fit into the above categories shall inform their immediate supervisor for work reassignment.

I have read the above statement and understand the possible health risk involved with occupational exposure to hazardous drugs.

____ ____________________

Employee Name (Print) Date

____

Employee Signature

LOW LEVEL RESPIRATORY PRECAUTIONS

POLICY:

Low Level Respiratory Precautions are used for residents who may have an undiagnosed pulmonary disease process that is unlikely to be TB. These Precautions are used during the diagnostic period.

PURPOSE:

Recognizing that it may be appropriate to order AFB testing for residents in whom pulmonary tuberculosis is not likely or suspected, an additional level of respiratory isolation was created to further prevent the likelihood of transmission.

PROCEDURES:

1. A resident for whom there is a low clinical suspicion for TB such as clinical findings with a high likelihood of a pulmonary process other that TB (e.g., bacterial pneumonia, *Pneumocystis carinii* pneumonia) is NOT considered suspect for TB. Low Level Respiratory Precautions are used when AFB testing is ordered on a resident in whom TB is not likely or suspected, but the definitive diagnosis is pending.
2. Medical staff, nursing staff or Infection Control may initiate Low Level Respiratory Precautions.
3. Nurse Manager/Charge Nurse of units with designated isolation rooms are to notify Plant Services prior to resident placement to perform maintenance services/repairs as needed.
4. A red door sign “STOP. Check With The Nurse Before Entering.” is posted on the outside of the resident’s door. Windows and door are kept shut at all times.
5. Medical staff or Infection Control may discontinue Low Level Respiratory Isolation.
6. Low Level Respiratory Precautions are used in addition to Body Substance Precautions.
7. Components of Low Level Respiratory Precautions:
   a. Resident placement
      i. Resident is placed in a private room. The door to the resident room is kept closed. Windows are to remain closed.
      ii. The resident is instructed to remain in room.
   b. Resident instruction
      i. The resident is instructed to cover mouth and nose with a tissue when coughing, and to discard the tissue appropriately into waste receptacle.

ii. The resident is instructed to wear a surgical-type mask whenever leaving room.

c. Masks

i. Masks are worn for respiratory protection to enter the resident's room. The mask designated as category N95 is used by all clinical personnel and others entering resident room.

8. In the event AFB is isolated from a smear or culture of a resident on Low Level Respiratory Precautions, the resident would then become suspect for TB and transferred to High Level Respiratory Isolation.

ATTACHMENTS:

None

REFERENCES:

None

Most recent review: 11/08/30 (Year/Month/Day)
Revised: 11/07/26
Original adoption: 05/11

Laguna Honda Hospital
Infection Control Manual

SECTION C: Hospital-Wide Policies

TITLE: **RESIDENT ROOM PLACEMENT GUIDELINES**

Purpose:

Resident room placement is assigned to minimize the potential for disease transmission to other residents and health care workers.

Statement of Policy:

Resident room placement is determined by each resident's suspected or confirmed diagnosis as determined by his/her physician. Most diagnoses allow placement of residents into open ward and semi-private rooms. Residents with potentially communicable diseases, whether suspect or confirmed, will be assigned rooms according to the resident care precautions guidelines adopted by LHH.

Procedure:

In accordance with the established system of resident care precautions at LHH, residents are placed as followed:

1. **High Level Respiratory Isolation** is required for residents with suspected or confirmed pulmonary *Mycobacterium tuberculosis* (TB), measles, and varicella (chicken pox).

   Residents requiring High Level Respiratory Isolation are placed in private rooms, maintained at negative pressure in relation to the corridors, and further engineered with HEPA filtration and/or special ventilation.

For additional details, see Infection Control Policies:
B2, Exposure Control Plan for Tuberculosis
C4, High Level Respiratory Isolation

2. **Low Level Respiratory Precautions** are used when AFB testing is ordered on a resident in whom active pulmonary *Mycobacterium tuberculosis* (TB) is not likely, but the definitive diagnosis is pending. Residents requiring Low Level Respiratory Precautions include those with a low clinical suspicion for TB presenting with clinical findings likely to be a pulmonary process other than TB (e.g., bacterial pneumonia, *Pneumocystis carinii* pneumonia).

A private room is required for Low Level Respiratory Precautions.

For additional details, see Infection Control Policies:
Exposure Control Plan for Tuberculosis
Low Level Respiratory Precautions

3. For decisions regarding **Special Contact Isolation** and the need for private rooms, consultation with the Infection Control staff is recommended.

For additional details, see Infection Control Policies:
Special Contact Isolation
Alphabetical List of Diseases/Conditions with Required Precautions

4. In addition to respiratory and special contact isolation, a private room is recommended for the following:

   a.) Residents with infectious disease transmitted by the respiratory route such as measles, mumps, plague, diphtheria, pertussis (whooping cough). See information for each under "Alphabetical list of Diseases, Conditions with Required Precautions" for those diseases requiring high or low level respiratory isolation,
   b.) Residents with **disseminated** Varicella Zoster infection,
   c.) Residents with extensive burns or skin loss,
   d.) Neutropenic residents (ANC$\leq$ 500), and
   e.) Residents with Norwegian scabies

5. To assist in the appropriate placement of residents upon admission, admission responsibilities have been defined as follows:

Physician & Clinical Staff:

a) Identify those residents who may require Isolation Precautions prior to admission for proper placement.
b) Inform admitting personnel of residents who require High Level Respiratory Isolation or Low Level Respiratory Precautions. Such residents may be required to wear a mask upon arrival at the hospital.
c) Inform residents of potential isolation requirements.
d) Admitting physician notifies the Infection Control staff if assistance with bed placement is needed.
e) Admitting physician or Infection Control staff notifies the nursing unit receiving the resident of Isolation or Precautions requirements.

6. The nursing staff, physicians, or Infection Control staff may identify a resident who develops a communicable disease after admission, and requires a change in room placement.

For additional details, see Infection Control Policies:
A10 Admission Policy

Reference:

San Francisco General Hospital Infection Control Manual, 2001, 2004.

Laguna Honda Hospital
Infection Control Manual

SECTION C: Hospital-Wide Policies

TITLE: **SPECIAL CONTACT ISOLATION**

Purpose:

To reduce the risk of transmission of epidemiologically important microorganisms that may be spread by direct or indirect contact, the Infection Control Staff will initiate Special Contact Isolation in coordination with the unit physician.

Statement of Policy:

Special Contact Isolation is instituted on a case-by-case basis for residents with specific conditions and potentially serious pathogens that may be transmitted by direct or indirect contact.

Procedure:

1. Body Substance Precautions, when practiced consistently, will generally reduce transmission due to direct or indirect contact. However, Special Contact Isolation may be required to further reduce the possibility for transmission of microorganisms which:
   - cause serious illness which may be difficult to treat due to multidrug-resistance,
   - can be easily transmitted by direct resident contact,
   - have the propensity to survive in the environment and be transmitted via indirect contact.

   Special Contact Precautions may also be initiated during an outbreak or increased incidence of nosocomial infections.

2. Implementation occurs at the discretion of the Infection Control staff in coordination with unit physician.

Special Contact Isolation may also be implemented when a particular organism is identified as being potentially hazardous to others and/or to the ecology of the hospital environment because of its pathogenicity, virulence, antibiogram, or epidemiologic characteristics.

3. Residents with the following conditions/organisms will be **considered** for Special Contact Isolation:

    - GI, respiratory, skin, and wound infections (or colonization) where body fluids are excessive and/or uncontained leading to excessive contamination of the resident's environment (e.g. stool incontinence).

    AND / OR

    - When identified with a multidrug-resistant bacteria that is difficult to treat with usual antimicrobials.

4. A Special Red door sign "STOP. Check with Nurse Before Entering" is posted at eye level, on the resident' s door.

5. Isolation will generally continue throughout hospitalization or until the resident is no longer considered a transmission risk as determined by Infection Control. For VRE, isolation may be discontinued.

6. In the event of an outbreak, additional requirements may be implemented. These include, but are not limited to:
    - increased cleaning of the resident environment.
    - limiting room entry to essential staff and visitors.

NOTE: Special Contact Isolation components are used in addition to Body Substance Precautions.

COMPONENTS OF SPECIAL CONTACT ISOLATION:

Resident placement

Residents should be placed as follows:

- In a private room
- Cohorted with another resident with identical organism and antibiogram (but with no other infections).
- Private rooms are indicated for residents who are infected or colonized by ARM when secretions are likely to contaminate the environment (patients with pneumonia or bronchitis and copious pulmonary secretions; wound drainage not contained by dressings; incontinent patients with VRE).

Attempts are made to maintain the resident in the same room for the duration of illness due to the need to thoroughly clean all environmental surfaces prior to subsequent resident contact.

Gloves/Hand hygiene

In addition to wearing gloves as outlined in Body Substance Precautions, wear gloves for direct contact with the resident or the resident's environment.

Clean, non-sterile gloves are adequate, except for procedures requiring sterile technique.

When providing resident care, change gloves after contact with infective material that may contain high concentrations of microorganisms, such as fecal material and wound drainage.
(Example: If resident has a respiratory infection with MRSA, gloves should be changed after oral care to avoid transfer of bacteria to other body sites. Wounds are especially susceptible to colonization with MRSA,

Remove gloves before leaving the resident's environment and practice hand hygiene immediately.

After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room. This will help avoid transfer of organisms to other residents or environments.

Mask

Wear a mask when entering the room of residents with respiratory infection or residents with colonization of the respiratory tract, who are coughing (including residents with tracheostomies).

Gowns

In addition to wearing a gown as described in Body Substance Precautions, wear a gown **if clothing is likely to have substantial contact with the resident or contaminated environmental surfaces in the resident's room.**

Clean, disposable, non-sterile gowns are adequate unless performing sterile procedures.

Remove gown before leaving resident's environment. Dispose of gown into trash receptacle unless reuse for same resident is anticipated, and gown not visibly soiled.

Appointment/Transfers

The person who makes an appointment for a resident in another department or facility shall notify the receiving department of the resident's ARM status.

Resident transport

The movement and transport of residents on Special Contact Isolation should be for essential purposes only. If transport and movement are necessary, the precautions should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.

Resident care equipment

When possible, the use of non-critical resident care equipment should be dedicated to a single resident on Special Contact Isolation.

Examples of non-critical items include:

- stethoscopes
- thermometers
- blood pressure cuffs/equipment
- commodes
- IV poles
- wheelchairs

If use of common equipment or items is unavoidable, then such items must be adequately cleaned and disinfected before use by another resident.

All reusable equipment MUST be thoroughly cleaned and disinfected after resident with a disease requiring Special Contact Isolation has been discharged and/or prior to use on another resident.

Support / ancillary services:

All personnel may enter the room of a resident on Contact Precautions. However, the use of gloves, gowns, and hand hygiene recommendations must be strictly followed.

*** Nutrition Services**

Nutrition Service will provide disposable utensils when serving food for residents in isolation rooms. Nursing will serve all food to resident on disposable plates using disposable utensils. Reusable food tray should not be brought inside the isolation room. Nursing staff will assure that disposable items are thrown away after use.

*** Environmental Services**

- Daily cleaning of Special Contact Isolation rooms will be performed in accordance with General Service/Housekeeping policies and Infection Control recommendations. More frequent cleaning is indicated when the environment is soiled. For example, an incontinent resident, wound drainage, a resident unable to comply with good hygiene practice.
- Terminal cleaning of rooms which housed residents on Special Contact Isolation is necessary prior to the transfer of a new

resident.

***Although it is impossible to rid the environment of all pathogenic organisms it is the intent of these procedures to reduce the colony counts of some special organisms on horizontal surfaces and in the immediate vicinity of the resident to reduce the opportunity for transmission of these organisms to others.**

***Medical Record**

Infection Control will indicate resident infected/colonized with Antibiotic resistant microorganisms (MRSA, VRE) by a label placed on the outside of the medical record, residents colonized/infected with antibiotic resistant organisms.

***Resident Education/ Precautions**

- Residents shall be instructed in hand hygiene procedures.
- Incontinent residents colonized with VRE shall be diapered.

References:

Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Committee (HICPAC), 1996. Guideline for Isolation Precautions in Hospitals.

Association of Professionals in Infection Control and Epidemiology (APIC) / Cummings, M.J., & Lynch, P. (1996) .Infection Control and Applied Epidemiology: Principles and Practice, Chapter 14, "Body Substance Isolation" (42 references).

Occupational Safety and Health Administration (OSHA), 1991. Occupational Exposure to Bloodborne Pathogens; Final Rule, Federal Register, 29 CFR Part 1910.1030.

San Francisco General Hospital Infection Control Manual, 2001, 2004.

Policy Number: D4
Revised: ~~November 2005~~August 2009

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **EVALUATION OF COMMUNICABLE ILLNESS IN PERSONNEL**

Purpose:

To minimize the risk for disease transmission at Laguna Honda Hospital (LHH), a policy is in place to evaluate personnel for communicable diseases.

Statement of Policy:

Personnel with communicable or potentially communicable disease are evaluated for work fitness to prevent transmission to residents and other health care personnel.

> Note: In all subsequent policies in section D of the Infection Control Manual, the term "personnel" is defined as all employees, volunteers, students, and medical staff working within the facility on a continuing basis, unless ~~otherwise stated~~otherwise stated.

Procedure:

1. LHH Employee Health Service has the authority to evaluate health care workers who have been exposed to or have symptoms of a communicable disease, and implement appropriate work restrictions or exclusions.

2. A health care worker with a communicable or potentially communicable disease must avoid resident contact and report illness to the Employee Health Service and the Infection Control Nurse.

3. Personnel who have had an exposure to a person with a communicable disease are required to report to the LHH Employee Health Service.

4. Personnel with the following symptoms should be evaluated for work fitness by LHH Employee Health:

* fever and chills
* persistent cough or sputum production consistent with tuberculosis.
* rash or vesicles
* skin lesions or weeping dermatitis
* draining wounds
* diarrhea or vomiting
* jaundice
* sore throat with fever
* red eyes / conjunctivae

~~1.~~5. The LHH Employee Health Service reports all exposures and suspected/confirmed cases of communicable disease in personnel to Infection Control.

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~~2.~~6. The Infection Control staff maintains responsibility for initiating a Contact Investigation if deemed necessary.

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NOTE: The remaining policies in section D of the Infection Control Manual are disease - specific. Each contains details including transmission risk, immunization requirements, definitions for infection and exposure, and work restrictions.

References

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **BLOODBORNE PATHOGENS AND PERSONNEL: HEPATITIS B, HEPATITIS C, HIV/AIDS**

Purpose:

Laguna Honda Hospital (LHH) has a program in place for assessment of risk and to minimize the likelihood for transmission of bloodborne pathogens to health care workers and ~~patients~~residents.

Statement of Policy:

The risk of transmitting bloodborne disease from health care workers to ~~patients~~ residents is minimal. LHH has confidential, voluntary evaluation process to provide guidance to health care workers infected with HIV, HBV, HCV, or other bloodborne pathogens.

Relevant Data:

1. Mode of transmission
Bloodborne pathogens, specifically human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV), are transmitted by percutaneous or mucosal exposures to blood and serum-derived body fluids from persons with acute or chronic infection.

The most effective means of preventing HIV, HCV and HBV transmission in health care settings is through strict adherence to ~~Body Substance~~Standard Precautions, which incorporate universal and barrier precautions, and established infection control practices. ~~Body Substance~~Standard Precautions decrease the opportunity for direct exposure to blood and body fluids for both health care workers and ~~patients~~residents.

Infected health care workers who adhere to universal precautions and who do not perform invasive procedures pose little or no risk for transmitting HIV, HCV or HBV to ~~patients~~residents.

Infected health care workers who adhere to universal precautions and who perform certain exposure-prone procedures, pose a small risk for transmitting HBV and HCV to ~~patients~~residents.

1. Procedure:

Hepatitis B screening and immunization:

a) Hepatitis B vaccine is offered to all personnel at LHH who are considered to have the potential for occupational exposure to bloodborne diseases (refer to Bloodborne Diseases Exposure Control Plan).

~~b)~~ Personnel who ~~have a~~have a reasonably anticipated contact with blood or other potentially infectious materials (as defined by the Bloodborne Disease Exposure Control Plan) are strongly encouraged to receive the Hepatitis B vaccine. At risk employees who decline vaccine must sign a declination form. ~~See attachment.~~

b)

c) Decision about serological screening prior to immunization shall be made on an individual basis.

d) Prior to receiving the Hepatitis vaccine series, the health care provider is counseled on benefits of vaccination, contraindications, possible adverse reactions, and the schedule of vaccinations.

e) Personnel who initially decline but decide they want the vaccine at a later date, will be given vaccine.

f) Anyone who develops symptoms of hypersensitivity after injection will not receive any further vaccine and vaccine is listed as an allergy. Personnel are instructed to notify their personal physicians regarding this.

[See also the Bloodborne Pathogen Exposure Control Plan ~~B1~~B2.]

2. Description of Illness

Detailed in Section ~~B1~~B2, Bloodborne Pathogen Exposure Control Plan.

3. Work restrictions for personnel Infected with bloodborne pathogens

HIV, HCV or HBV infection alone does not justify limiting a health care worker's professional duties. Limitations, if any, are determined on a case-by-case basis after

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consideration of the factors that influence transmission risk, including inability or unwillingness to comply with infection control standards or functional impairment which interferes with job performance.

Health care workers with an impaired immune system resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease.

Risk for disease transmission will be reduced by adhering to ~~Body Substance~~Standard Precautions, handwashing, and other infection control guidelines when performing patient care.

To protect any healthcare worker with impaired immunity, LHH Employee Health Service will:

- Offer the employee counseling about the potential risk associated with caring for ~~patients~~residents with infectious diseases.
- Educate the employee, stressing the importance of following the recommendations for infection control in order to minimize ~~the risk~~the risk of exposure to infectious agents.
- Follow the recommendations of the CDC Immunization Practices Advisory Committee (ACIP).
- Have in place institutional policies concerning requirements for vaccinating healthcare workers with live virus vaccines (e.g., measles, rubella).
- Assess whether a healthcare worker with an impaired immune system, especially those who perform invasive procedures, can adequately and safely be allowed to perform patient care duties or whether work assignments should be changed. Assessment will be determined on an individual basis. This decision will be made by the health care worker's personal physician in conjunction with the medical director of employee ~~health .~~health.

4. Definition of Exposure to bloodborne pathogens / Management

For details, refer to Section ~~B1~~B2, Bloodborne Pathogen Exposure Control Plan.

5. Work restriction for personnel Exposed to Bloodborne pathogens

None

~~**References:**~~

~~CDC (1998).~~

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Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **CAMPYLOBACTER INFECTION / EXPOSURE IN PERSONNEL**

Purpose:

Personnel with infections or exposure to campylobacter are evaluated and managed to prevent transmission to ~~patients~~residents and other personnel.

Statement of Policy:

Personnel are provided information regarding the epidemiology of Campylobacter and other gastrointestinal illnesses.

Procedure:

1. Mode of Transmission
Transmission is through the fecal-oral route. The most common source is contaminated food, especially poultry~~raw chicken~~.

2. Immunization Requirements
None / not applicable.

3. Description of Camplylobacter Infection
Campylobacter enteritis is an acute bacterial disease that can cause diarrhea, abdominal pain, fatigue, fever, nausea and vomiting. Illness generally lasts 2-5 days. Diagnosis is made by stool culture, generally obtained for severe diarrhea.

4. Work Restrictions for Personnel Infected with Campylobacter
Personnel may not work in health care facilities or in food service if they have been diagnosed with a campylobacter infection. Infection Control is to be notified and ~~P~~personnel may return to work upon proof of 3 successive negative stool cultures obtained ≥24 hours apart and taken at least 48 hours after completion of antibiotic therapy.

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1. having no symptoms for 24 hours,
2. completion of antibiotic therapy, and
3. clearance by Employee Health or Infection Control.

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5. Definition of Exposure to Campylobacter
Personnel are most likely to be exposed to infected household members, especially food preparers.

6. Work Restrictions for Personnel Exposed to Campylobacter
If personnel report a household member or other close contact may have exposed them to campylobacter, they should be educated to monitor for symptoms and should refrain from working if they become symptomatic.

For additional recommendations, see Policy D11: Diarrhea, vomiting, or acute GI illness in personnel.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.
NYS Department of Health (1996). Communicable Disease Fact Sheets.
CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **CYTOMEGALOVIRUS (CMV) INFECTION / EXPOSURE IN PERSONNEL**

Purpose:

To minimize risk for exposure to CMV during resident care and provide information on exposure/infection potential.

Statement of Policy:

Personnel will utilize ~~Body Substance~~Standard Precautions to minimize risk for exposure to CMV during resident care. Personnel will have available information to understand the epidemiology of CMV in health care setting.

Description of CMV Infection:

The clinical manifestation of CMV in adults is most commonly an extended~~, mononucleosis~~, mononucleosis-like illness.

> NOTE: Infection with CMV during pregnancy may have adverse effects on the fetus. Women of childbearing age should understand the need to adhere to ~~Body Substance~~Standard Precautions during resident care to reduce risk of occupational exposure.

Transmission of CMV:

CMV transmission occurs directly through close, intimate contact with an excreter or through contact with contaminated secretions or excretions, especially saliva and urine. Personnel providing care to residents at high-risk for CMV infections have no higher rate of primary CMV infection than those personnel without such contact.

Transmission of CMV by the hands of personnel has been suggested. Although CMV can survive on environmental surfaces and inanimate objects for short periods, there is not evidence that such contamination plays a role in transmission.

Adherence to ~~Body Substance~~Standard Precautions and good handwashing practices should eliminate health care provider contact with infectious secretions.

Work Restrictions for Personnel Infected with CMV:

Work restrictions for personnel who contract CMV illnesses are not necessary. Transmission risk from personnel to residents is negligible with adherence to handwashing and ~~Body substance~~Standard precautions.

Work Restrictions for Personnel Exposed to CMV:
No studies have demonstrated that seronegative personnel may be protected by transferring to patient care areas with patients less likely to be reservoirs for CMV infection

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Immunization Requirements:

None / not applicable.

References:

Wenzel, RP (1997). Prevention and Control of Nosocomial Infections

CDC (1998). Guideline for Infection Control in Health Care Personnel

Policy Number: D8
Revised: ~~November 2005~~August 2009

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **COLD SYMPTOMS IN PERSONNEL**

Purpose:

To minimize the risk of transmitting viral pathogens.

Statement of Policy:

Personnel with cold symptoms may work but are instructed to comply with infection control measures.

Procedure:

Personnel with cold symptoms are to comply with the following measures to prevent transmission:

- cover mouth and nose with tissue when coughing or sneezing, and dispose of tissue.
- wash hands immediately after use of tissue, after coughing and sneezing, and frequently throughout work shift.
- surfaces (i.e. doorknobs, telephone, etc.) that may have become contaminated with respiratory secretions should be cleaned using the towel or wipe saturated with a hospital-approved disinfectant.
- Fever is very uncommon with colds. Personnel with fever should be evaluated according to Policy D14.

NOTE: During a suspected or confirmed outbreak of respiratory syncytial virus (RSV) or influenza in the hospital or any other in resident setting, the management of personnel with cold symptoms may be redefined by the Infection Control team, with input from the Infection Control Committee (see Policies E18 and E27.)

Description of Infection/Infection Control Guidelines:

"Common colds" are acute infections of the upper respiratory tract primarily caused by over 100 types of rhinoviruses in adults.

Cold symptoms include cough, stuffy or runny nose, watery eyes, and fatigue.

Definition of Exposure:

Personnel exposed directly or indirectly to the respiratory droplets of an infected resident or family member with a cold should monitor themselves for symptoms, likely to begin approximately 48 hours after exposure. Control measures to prevent transmission (listed above) should be followed after exposure.

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Mode of Transmission:

Direct contact or inhalation of respiratory droplets can transmit "cold" viruses. The most likely method for transmission of colds, however, is by indirect hand contact.

Articles and surfaces which are freshly soiled by discharges of the nose and throat of an infected person are "picked up" on hands and transmitted when the carrier's hands touch the mucous membranes of his/her eyes or nose.

Immunization Requirements:

Not applicable/not available.

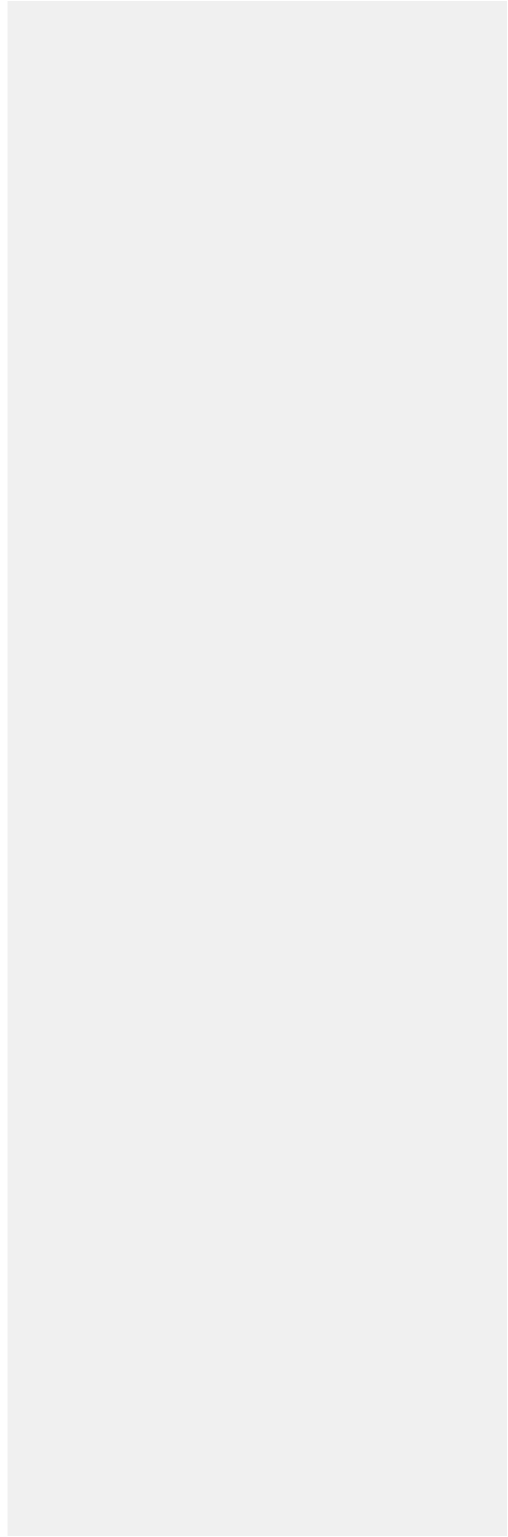
Work Restriction for Exposed Personnel:

None

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

CDC (1998). Guideline for Infection Control in Health Care Personnel.



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Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **CONJUNCTIVITIS IN PERSONNEL**

Purpose:

To prevent transmission of conjunctivitis to residents and other employees.

Statement of Policy:

Personnel are provided with information regarding infectious conjunctivitis to minimize the risk for transmission of eye infections to residents and other personnel.

Description of Illness/Infection Control Guidelines:

Symptoms of conjunctivitis include eye discharge/drainage, and any of the following: redness, itching, burning, and light sensitivity.

Many different bacteria and viruses can cause conjunctivitis, or eye infections. Adenovirus has been the primary cause of nosocomial outbreaks of conjunctivitis. Nosocomial outbreaks of conjunctivitis caused by other pathogens are rare.

Mode of Transmission:

Transmission can occur by direct or indirect contact with eye drainage or discharge from an infected person. Conjunctivitis is highly contagious.

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Transmission can be minimized by avoiding the use of common towels, linen, communal eye droppers / eye medications.

Adenovirus (the most common cause of health care associated conjunctivitis outbreaks) survives for long periods on environmental surfaces. Contaminated ophthalmologic instruments and equipment have been associated with outbreaks of conjunctivitis.

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Contaminated hands of health care workers are also a major source of person-to-person transmission of adenovirus, both from residents to health care personnel and personnel to residents.

Handwashing and adherence to ~~Body Substance~~Standard Precautions minimize the risk of conjunctivitis transmission.

Definition of Exposure:

Personnel who have had contact with eye drainage of a resident/family member with conjunctivitis should monitor themselves for symptoms. Incubation periods for conjunctivitis range from 24 hours to 12 days depending on the causative agent.

Work Restriction for Personnel with Conjunctivitis:

Personnel with conjunctivitis may not have resident contact until symptoms of eye drainage have resolved.

Personnel should be educated to avoid hand-to-eye contact.

Immunization Requirements:

None / not applicable

Work Restrictions for Exposed Personnel:

None.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

Bennett, M.D. & Brachman, P.S. (1992). Hospital Infections.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **COUGHING PERSONNEL**

Purpose~~/Statement of Policy~~:

Personnel with coughs are evaluated for cause of cough as not all coughs are infectious in nature. Personnel with cough that may be infectious are~~and~~ managed to minimize the risk of transmitting respiratory pathogens to residents and other personnel.

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Statement of Policy:

Information is provided regarding the assessment of coughs in personnel.

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Procedure:

Work Restrictions for Cough in Personnel
Coughing personnel are instructed to:

- cover mouth and nose with a tissue when coughing,
- dispose of tissue and wash hands immediately,
- avoid contamination of surfaces with respiratory secretions

NOTE: Personnel who are PPD positive are instructed to report promptly to Employee Health if symptoms of TB occur, including cough greater than 2 weeks in duration. It is a supervisor's responsibility to send an employee with chronic cough or other TB symptoms to employee health for evaluation.

Items and surfaces potentially contaminated with respiratory secretions by "mouthing" (e.g., telephone, doorknobs, etc.) must be promptly cleaned using a paper towel or wipe saturated with a hospital-approved disinfectant.

Personnel with uncontrollable cough or who are unable to practice the preceding infection control guidelines during their work shifts should refrain from working until their symptoms have resolved.

Immunization Requirements:

Not applicable

Description of Infection:

Many viral and bacterial pathogens and illnesses can result in symptoms of coughing.

Mode of Transmission:

Most infectious agents that cause coughing are transmitted via large respiratory droplets (emitted within generally a 3-foot radius of an infected resident).

~~Body Substance~~Standard Precautions include the recommendation for wearing a mask when performing providing care to residents who are ~~coughing to~~coughing to minimize exposure to respiratory secretions; in this circumstance the source is the healthcare worker and the exposure is minimized to the resident.

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EXCEPTION: Active pulmonary TB, caused ~~by *Mycobacterium*~~by Mycobacterium *tuberculosis*, can ~~be transmitted~~be transmitted via small droplet nuclei that can be carried on air currents. All personnel with a history of pulmonary tuberculosis and personnel with positive PPD tests may be at risk for developing active pulmonary TB disease.

References:

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **PERSONNEL WITH DERMATITIS ON HANDS**

Purpose:

To minimize the potential for transmitting infections to residents and other personnel.

Statement of Policy:

Personnel with draining dermatitis may not work in resident care areas until lesions have resolved.

Procedure:

Personnel with hand dermatitis consisting of vesicular or draining lesions must be evaluated by LHH Employee Health.

If personnel with hand dermatitis (determined to be of viral or bacterial origin) had resident contact, Infection Control should be notified to assess the likelihood for resident exposure.

Description of Hand Dermatitis:
Hand dermatitis is characterized by lesions or vesicles on hands that may or may not be draining.

Mode of Transmission:

Personnel with hand dermatitis may be unable to sufficiently wash their hands to remove transient bacteria and other potential pathogens. Such pathogens can be transmitted from health care personnel to residents.

> NOTE: Glove use is not sufficient to prevent personnel-to-resident transmission of all dermatitis-causing pathogens, such as Herpetic whitlow.

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Immunization Requirements:

Not applicable

References:

Bennett, J.V. & Brachman, P.S. (1992). Hospital Infections.

Wenzel, R.P. (1993). Prevention and Control of Nosocomial Infections.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: DIARRHEA, VOMITING, OR **ACUTE GI ILLNESS IN PERSONNEL (Diarrhea and/or Vomiting).**

Purpose:

Personnel with diarrhea, vomiting or other symptoms of acute gastrointestinal (GI) illness are evaluated and managed to minimize the risk of infection transmission to residents and other personnel.

To minimize the risk of infection transmission of gastrointestinal illness to residents and other personnel.

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Statement of Policy:

Personnel with acute diarrhea, vomiting, or other GI symptoms due to unknown causes or due to suspected or confirmed infectious pathogens are provided with information, evaluated for work fitness as necessary, and educated regarding transmission risks and prevention of diarrheal illness.

Description of Illness/Infection Control Guidelines:

GI infections may be caused by a variety of agents, including bacteria, viruses, and protozoa.

Acute GI illness is defined as diarrhea, vomiting, or both, with or without associated symptoms such as fever, nausea, and abdominal pain.

Diarrhea is a clinical syndrome that may be caused by a number of agents, and is characterized by frequent loose, watery stools. Diarrhea caused by infectious agents is often accompanied by vomiting, nausea, and fever.

Personnel with acute GI illness are likely to have high concentrations of the infecting agent in their feces or vomitus.

Mode of Transmission:

To minimize risk for transmitting pathogens that cause diarrhea, ALL personnel are instructed to wash hands thoroughly:

- after toileting
- prior to handling food
- after disposing of diapers
- after performing resident care

Healthcare personnel will adhere to Standard Precautions, which includes appropriate hand hygiene and use of personal protective equipment, when caring for patients. When patients are diapered, either due to age or incontinence, Special Contact Precautions may be required. Diarrhea illnesses caused by *Clostridium difficile* in staff or patients require hand washing with soap and water, as waterless alcohol hand cleaners do not kill clostridia spores.

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Although many agents cause acute GI infections, only a few agents have been documented in hospital transmission. The most frequently reported agents associated with healthcare outbreaks of GI infection are *C. difficile*, toxigenic *Staph aureus*, and rotavirus.

Hospital transmission of agents that cause GI infections usually results from:

- contact with excretions of infected residents,
- consumption of contaminated food, water, or other beverages, or
- exposure to contaminated objects or environmental surfaces.

Work Restriction for Personnel with acute GI Illness:

Personnel may not work in resident care areas or in food service if they have acute diarrhea and/or ~~with~~vomiting, with or without another GI symptom.~~ (as above).~~

~~Personnel may not work in resident care areas or in food service if they have been vomiting.~~

Personnel may return to work when symptoms resolve. If, however, diarrhea persisted for 3 days or more, personnel should contact Infection control or Employee Health and be evaluated by a physician prior to returning to work.

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Note: If personnel have a diarrheal illness diagnosed with the following causative pathogens, return to work may require approval by health regulation and Infection Control:

- Giardia
- E. coli 0157:H7
- Hepatitis A
- Salmonella
- Shigella

Immunization Requirements:

Not applicable

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

NYS Department of Health (1996). Communicable Disease Fact Sheets.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **DIPHTHERIA INFECTION/EXPOSURE AND PERSONNEL**

Purpose:

To minimize the risk of transmitting diphtheria to residents and other personnel.

Statement of Policy:

Information is provided to personnel to minimize the likelihood for diphtheria transmission.

Description of Illness/Infection Control Guidelines:

Diphtheria usually involves the throat (tonsils, pharynx, larynx) or the skin. is an acute disease often characterized by severe sore throat with presence of grayish/whitish membranous oral lesions.

Mode of Transmission:

Although currently a rare disease in the U.S., nosocomial transmission of diphtheria among residents and personnel has been reported. (Serosurveys have found up to 62% of adults may lack protective diphtheria antibody levels due to vaccine insufficiency.)

Diphtheria is transmitted by contact with respiratory droplets or contact with skin lesions of infected residents.

Adherence to ~~Body Substance~~Standard Precautions, including wearing a mask/eye shield, gloves for resident care, and performing handwashing upon completion, will minimize transmission likelihood.

Immunization Requirements:

Immunization with the tetanus and diphtheria toxoid (Td) is recommended every 10 years for adults.

Definition of Exposure/Management:

Personnel who had direct exposure to respiratory secretions or draining cutaneous lesions of a resident with diphtheria are considered to be exposed.

A course of antimicrobial prophylaxis should be administered to personnel who have been exposed (contact the Infectious Disease Service for most current ACIP recommendation).

A dose of TD should be given to exposed personnel who have not been vaccinated within the previous 5 years.

Daily for 7 days after exposure, nasopharyngeal cultures should be obtained and exposed personnel should be monitored for signs and symptoms of infection.

For personnel found to have positive cultures, nasopharyngeal cultures should be repeated 2 weeks after completion of antimicrobial therapy. Therapy should be repeated if personnel remain culture positive.

Work Restrictions for Personnel with Diphtheria Illness:

For symptomatic and asymptomatic personnel, exclude from work until antimicrobial therapy is completed and two nasopharyngeal cultures obtained at least 24 hours apart are negative.

~~A dose of TD should be given to exposed personnel who have not been vaccinated within the previous 5 years.~~

~~Daily for 7 days after exposure, nasopharyngeal cultures should be obtained and exposed personnel should be monitored for signs and symptoms of infection.~~

~~For personnel found to have positive cultures, nasopharyngeal cultures should be repeated 2 weeks after completion of antimicrobial therapy. Therapy should be completed if personnel remain culture positive.~~

Work Restrictions for Exposed Personnel:

Exposed personnel and personnel identified as carriers are excluded from duty until course of antimicrobial prophylactic therapy is completed and two nasopharyngeal cultures obtained at least 24 hours apart are negative.

Reference:

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
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SECTION D: Personnel Guidelines/Employee Health

TITLE: **ENTEROVIRUS / COXSACKIEVIRUS INFECTION/EXPOSURE IN PERSONNEL**

Purpose:

To minimize the ~~transmission of~~transmission of enterovirus/coxcakievirus infections to residents at highest risk.

Statement of Policy:

Information is provided to health care personnel to minimize the risk of coxsackievirus transmission to residents.

Description of Illness/Infection Control Guidelines:

Coxsackieviruses are members of the entrovirus group that cause a number of diseases. Although these viruses cause self-limiting, minor infection in adults, they can cause disseminated, severe disease in newborns and infants.

Characteristics of the 3 coxsackie viral diseases most easily transmitted are:

a. Vesicular pharyngitis / "Herpangina"
   Characterized by sudden onset of fever, sore throat, and small (1-2mm) grayish lesions on the back of the throat and mouth (may progress to ulcers)

b. Vesicular stomatitis with exanthum / "Hand, Foot, and Mouth Disease"
   Differs from vesicular pharyngitis (#1, above) in that oral lesions are more diffuse and may also occur on the insides of cheek and sides of the tongue. Papulovesicular lesions or exanthem may also appear on the palms of the hands, fingers, and soles of the feet.

c. Acute lymphonodular pharyngitis

Differs from vesicular pharyngitis (#1, above) in that oral lesions are firm, raised discrete white/yellow nodules surrounded by erythema. Lesions occur in the back of mouth and throat.

Mode of Transmission:

Three coxsackie viral diseases that may be transmitted via direct or indirect contact with infected respiratory secretions and infected stool are:

- Vesicular pharyngitis ("Herpangina")
- Vesicular stomatitis with exanthum ("Hand, Foot, and Mouth Disease")
- Acute lymphonodular pharyngitis

The risk of transmission may be greatly reduced by appropriate adherence to Standard Precautions, to include the proper wearing of mask / eye protection and proper hand hygiene measures.

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Work Restrictions for Personnel with Enteroviral infections:

Personnel diagnosed with or describing symptoms associated with an enteroviral disease as described above may not work with newborns, infants, or young children until symptoms resolve. Infection Control or Employee Health should be notified.

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Immunization Requirements.
Not applicable

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **FEVER IN PERSONNEL**

Purpose:

Personnel with fever are evaluated and managed to minimize the risk of transmission to residents and other personnel.

Statement of Policy:

Personnel are provided with information in order to evaluate work fitness for symptoms of fever.

Procedure:

1. Mode of transmission
Varied; depends on the causative agent.

2. Immunization requirements
Not applicable

3. Description of Fever or Febrile Illness

> NOTE: Since most acute onset fevers in normally healthy adults (i.e. health care personnel) are caused by infection, personnel with fever should refrain from work to avoid transmission of infectious diseases to residents and other personnel.

Fever is defined as a temperature above 100.6 F or 38 C.

4. Work restrictions for personnel with fever
Personnel are to remain out of work until fever resolves. If fever has persisted for 5 days or more, a physician evaluation should be obtained prior to returning to work.

References:

Mandell, GL, Douglas, RG, & Bennett, JE. (1988). Principles and Practice of Infectious Diseases.

Laguna Honda Hospital
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SECTION D: Personnel Guidelines/Employee Health

TITLE: **GIARDIA INFECTIONS IN PERSONNEL**

Purpose:

Personnel diagnosed with giardiasis will be managed to minimize the risk of disease transmission to residents and other personnel.

Statement of Policy:

Health care personnel are provided with information and guidelines regarding infections with Giardia.

Procedure:

1. Mode of transmission
Drinking unfiltered water from lakes and streams contaminated by infected feces can transmit the parasite that causes giardiasis.

Person-to-person transmission can also occur by hand-to-mouth transfer of Giardia cysts, primarily in settings with poor handwashing practices.

Three important measures to prevent transmission of Giardia and other such diarrheal-causing illnesses that can practiced by all:

- Careful and thorough handwashing after toileting (AND resident care)
- Careful disposal of sewage wastes so as not to contaminate surface or groundwater
- Avoid drinking improperly treated water

2. Immunization requirements
Not applicable

3. Description of Giardia infection

Giardiasis is an intestinal illness caused by a parasite, *Giardia lamblia*. Humans and some species of wild animals harbor the parasite in their GI tracts. (Giardia infection is also known as "beaver fever)."

People with giardia may have either mild or severe diarrhea. Some people infected with giardia develop chronic diarrhea, abdominal cramps, and bloating, and have significant weight loss.

4. Work Restrictions for Personnel with Giardia
Personnel diagnosed with giardiasis may not work in food service, resident care or handle resident medications.

Antibiotics are effective in treating Giardia.

Infection control or Employee Health should be notified.

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Personnel may return to work when asymptomatic and after completion of 5 days of antibiotic therapy.

5. Definition of Giardia Exposure
Personnel may be exposed to giardia if they drank unfiltered water or if a close family member (especially one who prepares food) has been diagnosed.

6. Work Restrictions for Exposed Personnel
Personnel who may have been exposed should monitor themselves for symptoms that generally occur 7 to 10 days after exposure.

If diarrheal symptoms occur, evaluation for work fitness should be determined by employee health.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

NYS Department of Health (1996). Communicable Disease Fact Sheets.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
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SECTION D: Personnel Guidelines/Employee Health

TITLE: **HEPATITIS A INFECTION / EXPOSURE IN PERSONNEL**

Purpose:

Personnel with Hepatitis A infection or exposure are evaluated and managed to minimize the risk of transmission to residents and other personnel.

Statement of Policy:

Personnel are provided with information and guidelines regarding Hepatitis A to reduce risk for transmission.

Procedure:

1. Mode of transmission

Transmission is "fecal-oral." Hepatitis A virus from an infected person's stool can contaminate food which may be consumed and cause infection.

Contaminated water due to improperly treated sewage has also caused Hepatitis A infections (both by swimming in and ingesting water, or eating uncooked shellfish harvested from contaminated water.)

Person-to-person transmission can be prevented by always washing hands after toileting.

Personnel can protect themselves from infection with Hepatitis A by adhering to ~~Body Substance~~Standard Precautions and practicing good handwashing after resident care.

NOTE: Health care workers should avoid eating food in resident care areas to reduce transmission risk of Hepatitis A.

2. Immunization Requirements for Hepatitis A

Once a person is infected and recovers from Hepatitis A, he/she is immune for life.

There is also a vaccine for Hepatitis A. However, it is not recommended by the CDC for routine immunization of health care workers.

The CDC does recommend the Hepatitis A vaccine for a number of groups with increased exposure risks, including laboratory personnel who work with Hepatitis A virus and health care personnel during a community outbreak.

3. Description of Hepatitis A Infection
Hepatitis A is a liver disease caused by a specific virus.

Onset of Hepatitis A infection is usually abrupt, with fever, malaise, poor appetite, and vomiting. Urine may become dark in color, and then the infected person develops "jaundice" (yellowing of the skin and eyes).

Once disease is clinically obvious, the risk of transmitting is already greatly decreased.

4. Work Restrictions for Personnel with Hepatitis A
Personnel are restricted from resident care areas and food handling until 7 days after the onset of jaundice.

Infection Control must be notified of personnel diagnosed with Hepatitis A.

Hepatitis A requires prophylactic therapy for those employees exposed to direct contact with excretions or secretions of infected persons or blood contact.

5. Definition of Exposure to Hepatitis A / Management
Hepatitis A is most transmissible prior to jaundice, approximately one week prior to symptoms appearing.

Personnel are considered exposed to Hepatitis A when they have had:

- accidental contact with excretions from a resident subsequently diagnosed with Hepatitis A (confirmed by antibody testing)
- a close family member or food preparer diagnosed with Hepatitis A

Immune globulin given as soon as possible after exposure to Hepatitis A minimizes the risk of developing the disease. (Immune globulin should not be given more than two weeks after exposure.)

6. Work Restrictions for Personnel Exposed to Hepatitis A
Exposed personnel must practice excellent handwashing and monitor themselves for symptoms of Hepatitis A.

The incubation period is 15 to 50 days.

If symptoms develop, personnel should be evaluated for work fitness by employee health and Infection Control notified.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

NYS Department of Health (1996). Communicable Disease Fact Sheets.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
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SECTION D: Personnel Guidelines/Employee Health

TITLE: **HERPES SIMPLEX INFECTION/EXPOSURE IN PERSONNEL**

Purpose:

Personnel with Herpes simplex infections are evaluated and managed to minimize the risk of disease transmission to residents and other personnel.

Statement of Policy:

Personnel are provided with information and guidelines regarding the risk of Herpes simplex transmission.

Procedure:

1. Mode of transmission
Transmission of Herpes simplex infections in healthcare settings is rare.

Transmission occurs through exposed/broken skin contact with primary or recurrent lesions or virus-containing secretions (i.e. saliva, vaginal secretions, or amniotic fluid).

The risk of transmission may be mitigated through the use of Standard Precautions.

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2. Immunization requirements
None / not applicable

3. **Description of Herpes simplex Infections**
Herpes simplex infections are characterized by localized lesions that tend to recur.

There are two virus types (I and II) which cause herpes simplex infections.

Herpes simplex infections can manifest as cold sores on lips, lesions in genital areas, or as hand/finger lesions (called herpes Whitlow).

4. Work Restriction for Personnel with Herpes simplex infections
Personnel with cold sores may work, but must practice good handwashing, especially before resident care.

Personnel may wish to cover the cold sore with a bandage or mask to prevent selves from contaminating their hands by touching the lesion.

Personnel with lesions on fingers suspected or confirmed to be Herpes may not work until lesions heal. (It is not known whether gloves are sufficient to prevent transmission of this highly infectious condition).

There are no work restrictions for personnel with genital lesions. As always, handwashing is required after toileting.

References:

Benenson, A.S. (1995). Control of Communicable Disease Manual.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **INFLUENZA IMMUNIZATION / INFECTION IN PERSONNEL**

Purpose:

To minimize the risk of influenza illness within the facility, an active program is in place that emphasizes annual immunization, cough etiquette, and education

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Statement of Policy:

In addition to providing information regarding influenza transmission, LHH offers free, annual influenza immunization to all personnel to reduce the risk of transmission to residents, residents, and other personnel.

Procedure:

1. Mode of transmission
Transmission is most likely via contact with large particle droplets of respiratory secretions. However, transmission by small airborne nuclei has also been demonstrated.

To reduce likelihood for influenza transmission, health care providers may be required to increase use of mask/eye protection during the known community "flu" epidemics. [Respiratory isolation protocol may also be considered in the future, especially during outbreaks.]

2. Immunization requirements
According to annual CDC guidelines, Employee Occupational Health provides an influenza immunization program incorporating current information regarding type of vaccine to be offered and the date to initiate immunization.

Generally, annual influenza immunization is recommended during the month of November to ensure immunity lasts through the entire influenza season, which often does not end until March of the following year.

Employee Health assesses availability of the vaccine, generates a letter to administrative staff, and disseminates information to personnel via a variety of forums, including E-mail and internal publications.

Prior to immunization, personnel are counseled regarding the benefits of immunization, the annual vaccine type, the potential side effects and restrictions, and signed consent forms are obtained.

The Health and Safety Code (Title 22) of the State of California requires that health care workers annually receive influenza vaccine in the appropriate season, or sign a declination form.

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3. Description of Influenza-like Illness:
The criteria for defining influenza-like illness includes:

a. fever > 100~~.6~~ F
AND
b. cough or sore throat
AND
c. physician judgement of influenza / other confirmed cases in the geographic area

NOTE: Personnel who receive the influenza vaccine may still develop influenza-like illness. However, symptoms are generally less severe, the course of illness is of shorter duration, and there is less likelihood of developing secondary infections.

Personnel with Influenza-like illness must report to the supervisor. The supervisor shall contact Infection Control and if the employee has become ill at work, a mask will be provided to the employee with instruction to report to Occupational Health for rapid influenza A and B screening. The employee will go home to await contact by Infection Control regarding test results.

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~~Personnel with Influenza-like illness must report by telephone or in person to Employee Health.~~

4. Work Restrictions for Personnel with Influenza-like Illness
Personnel who meet the clinical or laboratory criteria for influenza-like illness (above) should not work until 5 days after the onset of symptoms.

5. Definition of Exposure to Influenza
A person is considered exposed to influenza if he/she had close contact (within 3 feet) for 5 minutes or more with a confirmed clinical case of influenza without use of appropriate personal protective equipment..

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Influenza is considered infectious or transmissible from 24 hours before to 5 days after the onset of symptoms.
Infection Control should be notified of exposures that occurred in the facility.

6. Work Restriction for Personnel Exposed to Influenza:
Personnel exposed to influenza should monitor themselves for illness, which generally occur within 1 to 3 days after exposure. (If symptoms are consistent with influenza-like illness, work restrictions apply.)

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

CDC (1996). Pilot Testing a National Surveillance System for Hospital Health Care Workers (NASH Program).

CDC (1998). Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **LICE (PEDICULOSIS) INFESTATION / EXPOSURE IN PERSONNEL**

Purpose:

Personnel infected or exposed to lice are evaluated and managed to prevent transmission to residents and other personnel.

Statement of Policy:

Personnel with lice and exposures to lice are provided with the information and guidelines for management.

Procedure:

1. Mode of transmission

Head lice are transmitted only by direct contact with an infested person or objects used on the hair (combs, brushes, etc.)

Body lice can be transmitted by both direct or indirect contact with the infested person or his/her personal belongings, especially shared clothing and headgear.

2. Immunization
Not applicable

3. Description of lice Infestation
Three types of lice are human parasites: body lice, pubic or crab lice, and head lice.

Body and head lice look similar and are approximately 2 -4 mm in length. Only body lice are vectors for human pathogens (typhus, trench fever, relapsing fever), thought these are rare.

Body lice are found in clothing, especially along the inner seams.

Head lice occur in hair, eyebrows and eyelashes, and "nits" (collections of eggs) can be found in the hair.

Pubic lice look "crablike" and are smaller than body lice, only 1-2mm in length. Crab lice are found in pubic hair.

Lice feed on human blood, resulting in severe itching of the infested area:

4. Personnel with lice Infestation
Personnel with head /body lice need to be identified as quickly as possible.

Personnel symptomatic for lice should be examined by Employee Health or the Emergency Department. Examination includes a thorough check for nits. Nits are detectable in the hair, most commonly in the occipital region and above the ears. Dermatitis may also be noted.

Infection Control should be notified of personnel with suspected or confirmed lice infestation who have had resident contact while infested.

5. Work Restrictions for Personnel with Lice
Personnel with lice are removed from work until 12 hours after treatment with a hospital-approved treatment. Lindane (Kwell®) is not approved for use, and is illegal to use since Jan. 1, 2002.

[The Infectious Disease Service is contacted for appropriate agent and dosing.]

Retreatment may be recommended to ensure no eggs have survived.

Personnel are instructed to wash clothing and linen in hot water, and to inform all out-of-hospital contacts of the need for treatment to prevent reinfestation.

Infection Control will assist personnel in assessing exposure contacts and required follow-up.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

NYS Department of Health (1996). Communicable Disease Fact Sheets.

CDC (1998). Guideline for infection control in health care personnel

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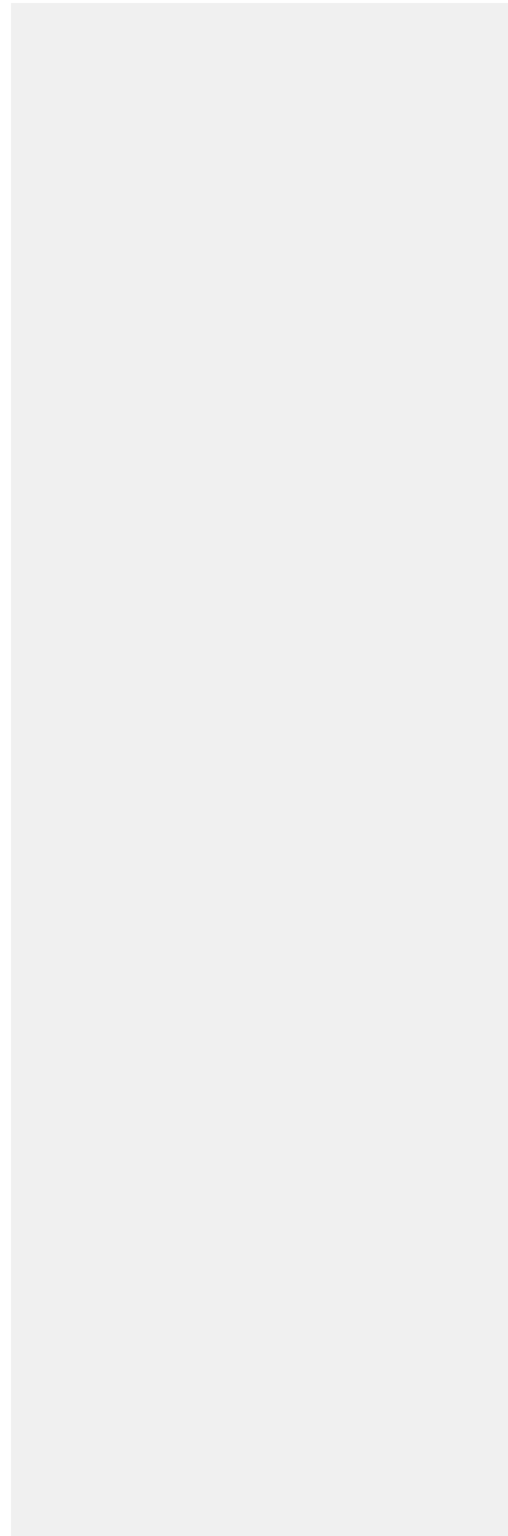

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **MEASLES AND PERSONNEL**

Purpose:

Laguna Honda Hospital (LHH) has a program in place to minimize the likelihood for transmission of measles to patients and health care workers.

Statement of Policy:

All health care workers at LHH shall be required to demonstrate adequate ~~protection~~ immunity against measles (rubeola) virus.

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Procedure:

1. Mode of transmission

Measles are transmitted both by large respiratory droplets during close contact between infected and susceptible persons and through the airborne route by suspended small aerosolized viral particles. Measles is highly transmissible.

2. Immunization requirements

a. Individuals born prior to January 1, 1957 are considered immune.

b. Individuals born on or after January 1, 1957 must present documentation prepared by a physician, physician's assistant, specialist's assistant, nurse practitioner or a laboratory demonstrating:
    1. diagnosis by a physician as having had measles disease or;
    2. serological evidence of measles antibody or;

3. two doses of live virus measles vaccine with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age, showing the product administered and the date of administration and prepared by the health practitioner who administered the immunization or;
4. a copy of a document described in (a), (b), or (c) above which comes from a previous employer or school which the employee attended as a student.

c. In the case of a negative antibody titer, 2 immunizations, at least 30 days apart, will be required. (Routine serologic testing for measles is not required prior to administration of measles vaccine.)

d. If any licensed physician, physician's assistant, specialist's assistant, or nurse practitioner certifies that immunization may be detrimental to the employee's health, the requirements of this policy relating to immunization shall be inapplicable until such immunization is found no longer to be detrimental to the employee's health. The nature and duration of the medical exemption must be stated in the employee's medical record and must be in accordance with general accepted medical standards. The health care worker will be counseled by a physician or his/her designee regarding measles, appropriate precautions and the risk of transmission of the disease.

e. In the case of an outbreak, health care workers who received their most recent dose of measles vaccine before 1980 should be revaccinated.

3. Description of Measles Illness

To be defined as measles, the following clinical criteria must be met:

- generalized rash lasting > 3 days,
- AND fever > 101 F,
- AND cough, coryza, or conjunctivitis.

Measles can also be defined by laboratory tests including the isolation of the virus from a clinical specimen, a significant rise in measles antibody level by standard serologic assay, or positive serologic test for measles IgM antibody.

A person may transmit measles infection from 5 days prior to 7 days after onset of rash.

NOTE: All suspected or confirmed cases of measles in the community or facility should be reported promptly to Infection Control.

4. Work restrictions for personnel with Measles

A health care worker with diagnosed measles shall be relieved from work immediately and for a period of 7 days following the appearance of the rash of for the duration of acute illness, whichever is longer.

5. Definition of Measles Exposure / Management

To be considered exposed to measles, a person must:
- be susceptible to measles
- have shared airspace within the same room for 5 minutes or more with a confirmed or probable case of measles

Note: Since all newly hired health care workers are required to verify immunity status or be vaccinated for measles there should not be susceptible health care workers at LHH.

In the event persons are susceptible and exposed to measles, measles vaccine should be administered within 72 hours after the exposure or, in certain situations, serum globulin may be administered within 6 days of exposure.

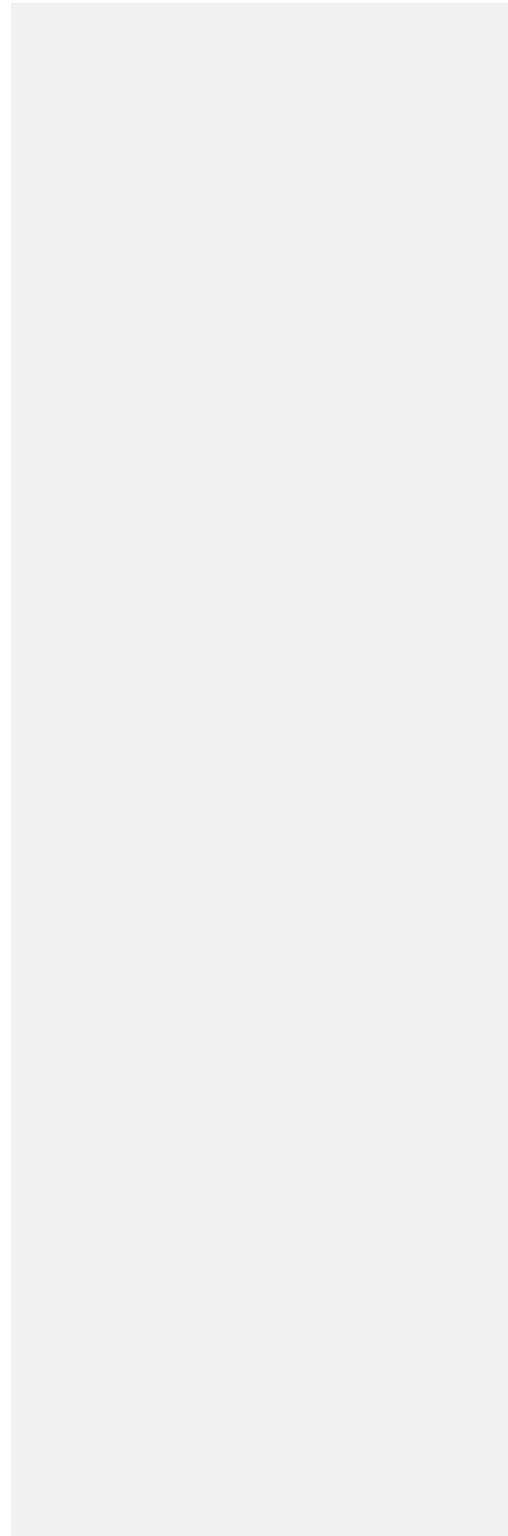
6. Work restrictions for personnel Exposed to Measles

Any unprotected health care worker shall be removed from work on day 5 through day 21 after exposure. If active infection occurs, the health care worker shall be removed from work immediately and for a period of 7 days after rash appears.

References:

CDC (1996). Pilot Testing a National Surveillance System for Hospital Health Care Workers (NASH Program).

CDC (1998). Guideline for Infection Control in Health Care Personnel.



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SECTION D: Personnel Guidelines/Employee Health

TITLE: **MENINGOCOCCAL DISEASE AND PERSONNEL**

Purpose:

Laguna Honda Hospital (LHH) has a policy to minimize the potential for exposure and transmission of meningococcal disease in ~~patient~~residents and health care workers.

Statement of Policy:

LHH has a program in place to coordinate the investigation, reporting and prophylactic treatment of ~~patient~~residents and personnel exposed to invasive meningococcal disease, through a wording collaboration of Infection Control and LHH Employee Health Service.

Procedure:

1. Mode of transmission

Neisseria meningitidis is transmitted through mucous membrane contact with large droplets in respiratory secretions of patients with meningococcemia, meningococcal meningitis, or lower respiratory tract infections caused by *N. meningitidis.*

~~Nosocomial~~Health care associated transmission is rare.

2. Immunization requirements

None

3. Meningococcal disease
Invasive disease caused by *Neisseria meningitidis* is most commonly meningococcemia and/or meningitis. Less commonly *N. meningitidis* may cause primary pneumonia.
Persons with *N. meningitidis* are rendered noninfectious by 24 hours of effective therapy.

For the care of the ~~patient~~resident admitted with known meningococcal disease, health care personnel will continue to practice ~~Body Substance~~Standard Precautions, but will **wear a mask when providing all direct care or when within 3 feet of the ~~patient~~resident** for 24 hours after the start of appropriate antibiotic therapy.

4. Work restrictions for personnel with Meningococcal disease

(Personnel with meningococcal disease will be excluded from work for 24 hours after start of effective therapy or until they feel well enough to return to work whichever comes first.
~~(though may be quite ill and require additional sick leave).~~

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5. Definition of Meningococcal Exposure

Health care workers are rarely at risk when caring for infected ~~patient~~residents.

Personnel would be considered exposed if mouth-to-mouth resuscitation, intubation, or suctioning is done without protective barriers (fluid shield mask, eye protection, resusi-mask). Notify Infection Control of suspected exposure.

Prophylaxis is not recommended routinely for health care workers except those who have had intimate exposure to the respiratory secretions of an infectious person.

If prophylaxis is indicated, it should be given as soon as possible, preferably within 24 hours after exposure. Antibiotic prophylaxis will be administered by Employee Health (or Emergency Department when Employee Health Service is closed).

6. Work restrictions for personnel Exposed to Meningococcal disease

All health care workers who may have had exposure to the infected person before antibiotic therapy was begun would be considered at low risk for infection. They should be counseled regarding early signs of disease. Exposed individuals who develop a febrile illness should remove selves from work and receive prompt medical attention.

References:

CDC (1998). Guideline for Infection Control in health Care Personnel

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SECTION D: Personnel Guidelines/Employee Health

TITLE: **MUMPS AND PERSONNEL**

Purpose:

To minimize the risk of transmission of mumps to residents and other personnel, a plan to evaluate personnel for mumps is in place.

Statement of Policy:

Personnel are provided with information and management guidelines regarding mumps.

Procedure:

1. Mode of transmission

Transmission of mumps occurs by direct contact with large particle respiratory droplets or by direct contact with the saliva of an infected person.

The risk of transmission between personnel and residents may be mitigated through the proper use of Low Level Respiratory Isolation.

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2. Immunization requirements

a. Proof of mumps immunity is currently required by health care workers in LHH.

b. Generally, persons can be considered immune to mumps if:
   - they were born before 1957,
   - have serologic evidence of mumps immunity,
   - have documentation of physician-diagnosed mumps, or
   - have documentation of vaccination with at least one dose of live mumps vaccine on or after their first birthday.

c. Demonstration of mumps IgG antibody by any commonly used serologic assay is acceptable evidence of mumps immunity. Persons who have an "equivocal" serologic test result should be considered susceptible to mumps.

d. For those personnel who do not have evidence of mumps immunity as identified above the immunization will be administered as below :

- Health-care workers with no history of mumps vaccination and no other evidence of immunity will receive 2 doses (at a minimum interval of 28 days between doses).
- Health-care workers who have received only 1 dose previously will receive a second dose.
- For unvaccinated workers born before 1957 whom do not have a history of physician-diagnosed mumps or laboratory evidence of mumps immunity; 1 dose of a live mumps virus vaccine.

Commented [s2]: Update from SFGH Policy

~~Although recommended, proof of mumps immunity is not currently required by health care workers in California.~~

3. Description of Mumps Infection

Mumps, or infectious parotitis, is a common childhood disease, affecting over 85 percent of people by adulthood. In the US, the incidence of mumps has declined dramatically since wide use of a mumps vaccine became available in 1967. Mumps infection may cause more extensive disease in susceptible adults, especially males.

Mumps is generally seen in the winter and spring seasons.

To be defined as mumps, an ill person must meet the following clinical criteria:

- acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland, lasting > 2 days, without other apparent cause.
- ~~acute onset of unilateral or bilateral tender, self-limited~~
- ~~swelling of the parotid or other salivary gland, lasting > 2 days,~~

~~AND~~

- ~~without other apparent cause.~~

Commented [s3]: Proper sentence

Mumps can also be confirmed by lab testing, including the isolation of the mumps virus from a clinical specimen, or significant rise in mumps antibody level by serologic assay, or positive serologic test for mumps IgM antibody.

Infection Control must be notified of any mumps infections or exposures in personnel or residents.

4. Work restrictions for personnel with Mumps

Personnel diagnosed with mumps are removed from work until 9 days after the onset of parotitis (swelling).

Personnel with mumps symptoms or diagnosis must report in person or by telephone to Employee Health.

5. Definition of Mumps Exposure

To be considered exposed to mumps, a person must:

- be susceptible to mumps
- have prolonged (>1 hour) of close contact (within 3 feet) with a probable case.

A person with mumps is infectious and may transmit the disease from 2 days before to 9 days after onset of parotid swelling.

6. Work restrictions for personnel Exposed to Mumps

Personnel exposed to mumps should be tested for susceptibility. If susceptible, personnel may not work from 12 days (after the first exposure date) to 26 days (after the last exposure date).

References:

Benenson, A.S. (1995) Control of Communicable Diseases Manual.

CDC (1998). Guideline for Infection Control in Health care Personnel.

CDC (1996). Pilot Testing a National Surveillance System for Hospital Health Care Workers (NASH Program).

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **RUBELLA AND PERSONNEL**

Purpose:

To minimize the risk of transmission to susceptible residents and others, personnel at Laguna Honda Hospital (LHH) must demonstrate immunity to rubella.

Statement of Policy:

During the late 1980's, the incidence of rubella increased in the young adult population, prompting public health agencies to increase immunization efforts. The occurrence of rubella in hospital personnel can present a significant risk to pregnant women and their unborn children. Eliminating rubella susceptibility in personnel eliminates this risk.

Procedure:

1. Mode of transmission
Rubella is transmitted by contact with nasopharyngeal droplets from infected persons. The disease is most contagious when rash is first erupting, but virus may be shed from one week prior to one week after onset of rash.

2. Immunization requirements
In accordance with US Public Health Service Advisory Committee on Immunization Practices:

1. Preplacement immunizations are routine and mandatory unless proof of immunity can be provided, i.e., positive serologic test or documentation of previous vaccination subsequent to first birthday.

2. Occupational/Employee Health will obtain titers from all newly hired persons as part of preplacement screening. No screening is indicated if personnel presents positive proof of serologic testing or presents documented proof of previous vaccination.

3. All newly hired hospital personnel, both male and female, receive the vaccine if indicated

4. All newly hired personnel will read an information sheet and sign a release of responsibility form prior to receiving vaccine.

5. Contraindications to immunization include:
   - Pregnancy
   - Allergy to neomycin
   - Febrile respiratory illness or other active febrile infection
   - Active untreated tuberculosis
   - Residents receiving immunosuppressive therapy
   - Individual with blood dyscrasias, leukemia, lymphomas of any type or other malignant neoplasms affecting the bone marrow.

6. Special considerations for designated personnel include:

Students: It will be the responsibility of the school, college or university to ensure that prior to affiliation at LHH, rubella screening consistent with hospital policy is done.

Medical Staff: It will be the responsibility of the medical staff, at the time of credentialing, to show proof of rubella status consistent with hospital policy.

3. Description of Rubella Infection

To be defined as rubella, the following clinical criteria must be met:

- acute onset of generalized maculopapular rash,
- AND temperature > 99 F (if measured),
- AND arthritis/arthralgia, lymphadenopathy (swollen glands), or conjunctivitis.

Rubella may also be defined by laboratory testing including isolation of rubella virus, or significant rise in rubella antibody level by standard serologic assay, or positive serologic test for rubella IgM antibody.

4. Work restrictions for personnel with Rubella

Persons who meet the clinical criteria for measles should be excluded from work until 7 days after appearance of rash.

5. Definition of Rubella Exposure

To be considered exposed to rubella, a person must:

- be susceptible to rubella
- have maintained close contact (within 3 feet) with a probable case for 5 minutes or more
- have had any direct contact with an infant diagnosed with congenital rubella syndrome

Persons are considered infectious and may transmit rubella from 3 days before to 7 days after the onset of rash.

6. Work restrictions for personnel Exposed to Rubella

All newly hired personnel working within LHH should be immune to rubella. However, in the event that person is found to be susceptible and exposed to rubella, he/she must be excluded from work from 7 days after first exposure through 21 days after last exposure.

References:

CDC (1996). Pilot Testing a National Surveillance System for Hospital Health Care Workers (NASH Program).

CDC (1998). Guideline for infection control in health care personnel.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **SALMONELLA INFECTION AND PERSONNEL**

Purpose:

Laguna Honda Hospital has a policy in place to reduce the likelihood for transmission of Salmonella among residents and health care personnel.

Statement of Policy:

Personnel are provided with education and management guidelines for Salmonella infection and exposure.

Procedure:

1. Mode of transmission

Salmonella is transmitted via the fecal-oral route, both from an animal and human sources.

Contamination of food with Salmonella is a likely source for transmission, especially raw / undercooked eggs, poorly cooked meat and poultry, unpasteurized milk and milk products.

2. Immunization requirements
None

3. Description of Salmonella Infection

Salmonella is most often recognized when it presents as an acute bacterial infection of the GI tract. Human disease is caused by over 200 known serotypes in the US.

Symptoms include sudden onset of fever, abdominal pain, diarrhea, nausea and/or vomiting. Asymptomatic infections may also occur.

4. Work restrictions for personnel with Salmonella

Infection control and Employee Health should be notified of personnel with salmonella infection.

Health care personnel may not work until they have remained symptom-fee for 48 hours after completion of antibiotic therapy.

Health care personnel may not work until they have 2 successive negative stool specimens obtained 24 hours apart and taken 48 hours after completion of antibiotic therapy.

Commented [s1]: Changed policy from SFGH

5. Definition of Salmonella Exposure

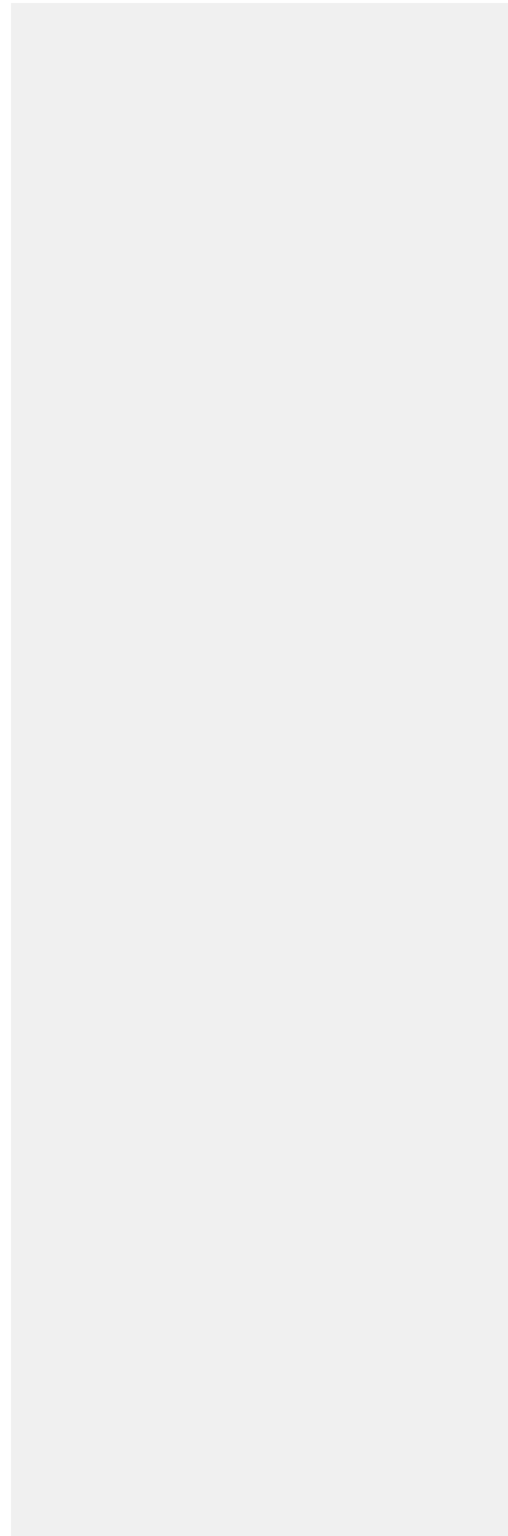
Exposures to Salmonella among health care personnel are most likely to occur outside of the health care setting, such as if a close family member or food provider has been diagnosed with Salmonella.

Note: Adherence with Body SubstanceStandard Precautions and handwashing guidelines should prevent exposure of personnel form infected residents.

However, in the event a health care worker has had mucous membrane or extensive skin exposure to the feces of a resident diagnosed with salmonella, contact Infection Control for specific recommendations.

6. Work restrictions for personnel exposed to Salmonella

None. Monitor for symptoms.



Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **SCABIES INFESTATION / EXPOSURE IN PERSONNEL**

Purpose:

Personnel infected or exposed to scabies are evaluated and managed to prevent transmission to residents and other personnel.

Statement of Policy:

Personnel with scabies and exposures to scabies are provided with information and guidelines for management.

Procedure:

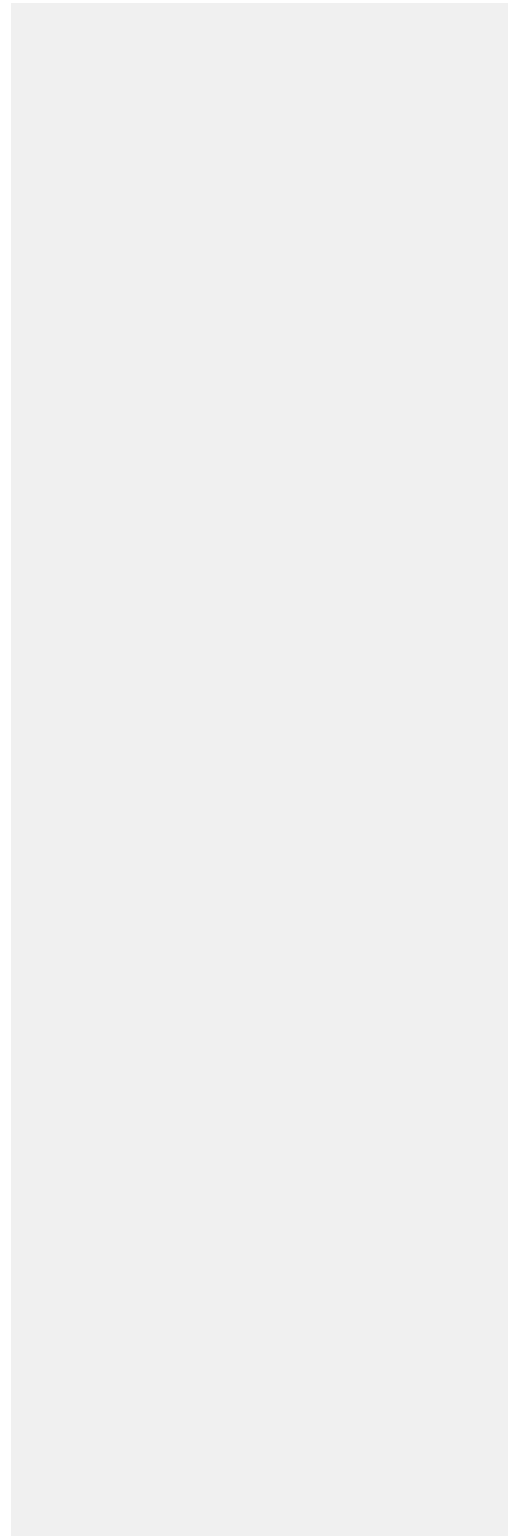
1. Mode of transmission

Transmission of scabies occurs primarily through prolonged skin-to-skin contact with a person who has conventional scabies; therefore, the diagnosis of scabies should be considered in any patient with pruritic rash, especially involving hands, wrist, and elbows.

Commented [s1]: Added to the policy from SFGH

Shorter periods of skin to-skin contact with person who have a crusted scabies form (i.e. "Norwegian" scabies) may also result in transmission.

NOTE: ~~Body Substance~~Standard Precautions requires the routine use of barriers (gloves/gowns) by personnel to avoid skin-to-skin contact with non-intact skin and rashes of residents. Therefore, personnel at LHH should routinely avoid exposure to scabies by adhering to the principles of Body substance Precautions as the standard of care (refer to Policy C 02 for additional details).



2. Immunization requirements

Not applicable

3. Description of Scabies Infestation

Symptoms of scabies always includes rash, however the rash varies greatly - may appear as small lines, pustules or blisters.

Rash usually found between fingers, front of wrists, elbows, axilla, belt line, thighs, genitalia, nipples, abdomen, and the lower portion of the buttocks.

Rash causes intense itching, especially at night.

4. Work restrictions for personnel with Scabies

Employees with scabies are placed on work restrictions to prevent transmission of scabies to residents and other staff members.

Personnel must remain out of work until 8-12 hours after appropriate treatment with a scabicide agent.

Notify Infection Control of any cases of scabies in health care providers.

5. Definition of Scabies Exposure

Significant exposures include:

- Family members.
- Sexual contacts.
- Anyone who had skin to skin contact with infested individual.

Prophylactic scabicides are not routinely recommended for personnel following minor skin-to-skin exposures.

Possible exposures to scabies and management should be evaluated on a case-by –case basis by consultation with Infection Control.

In situations where scabies transmission has occurred, scabicide treatment may be recommended to personnel who may have had skin-to-skin contact.

6. Work restrictions for personnel Exposed to Scabies
None unless symptoms occur. Notify Infection Control.

References:

Benenson, A.S. (1995). Control of Communicable Diseases Manual.

NYS Department of Health (1996). Communicable Disease Fact Sheets.

CDC (1998). Guideline for infection control in health care personnel.

APPENDIX B

PROCEDURE FOR SKIN SCRAPING

Skin scrapings should always be performed by a clinician who is trained to perform the procedure. Nurse practitioners and physician's assistants can also perform the procedure if they have been trained by a clinician.

1. Obtain the following equipment
   - gloves and gowns
   - slides and cover slips
   - magnifying lens and light source such as goose neck lamp
   - alcohol impregnated wipes
   - felt tip pen (green or blue)
   - Clear nail polish (if applicable)
   - Mineral oil and dropper
   - Applicator sticks
   - Surgical blade
   - Sharps container
   - Compound microscope (if available)

2. Procedure
   a. Observe resident's skin with a magnifying lens and look for lesions suggestive of scabies infestations. The shoulders, back, abdomen, hands, wrists, elbows, buttocks, axillae, knees, thighs and breasts are common sites for burrows.

   b. Using a hand-held magnifying lens and a strong light, look for new burrows or papules. If the burrow or papule is very fresh, a tiny speck (mite) may be visualized at either end of the burrow or in the papule. The mite will not be found in excoriated, scabbed or infected skin lesions. Preserved, unscratched papules may sometimes be found in a grouping of scratched papules.

   c. Visualize burrows using the "burrow ink test" described in the text.

   d. Select an unexcoriated burrow or papule.

e. Prepare slides by dipping an applicator stick into mineral oil and transferring 2-3 drops to the center of several clean slides.

f. Dip a hypodermic needle into the mineral oil and transfer a drop of oil to the lesion selected for scraping and spread the oil evenly over the intended scraping site.

g. Hold the skin taut with one hand and hold the hypodermic needle at about a 5-10 degree angle with the other hand. If a surgical blade is used, hold blade at a 90-degree angle.

h. Apply light pressure and scrape the lesion making several movements across the lesion. Increase the pressure slightly while scraping. A small amount of blood may be visible, however, there should be no frank bleeding.

i. Transfer skin scrapings to prepared slide and place a cover slip over the scrapings.

j. Obtain at least 4-6 scrapings per resident.

k. Examine the entire slide preparation under lower power magnification for evidence of mites, eggs or fecal pellets. If a compound microscope is not available at the facility, secure the cover slips with clear nail polish and transport slides to a clinical laboratory, physician's office or local public health laboratory.

If more than one resident has signs or symptoms of infestations, repeat the procedure using clean equipment on at least one other symptomatic resident. If health care workers are symptomatic, skin scrapings should be performed on at least one (1) symptomatic health care worker.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **SHIGELLA INFECTION AND PERSONNEL**

Purpose:

Laguna Honda Hospital has a policy in place to reduce the likelihood for transmission of Shigella among residents and health care personnel.

Statement of Policy:

Personnel are provided with education and management guidelines for Shigella infection and exposure.

Procedure:

1. Mode of transmission
Shigella is transmitted via the fecal-oral route, with or without contamination of food.

The source for shigella is primarily feces of infected persons.

Prevention of transmission requires emphasis on handwashing before handling food and after toileting.

2. Immunization requirements
None

3. Description of Shigella Infection

Shigellosis is an acute infection of the GI tract. Human disease is caused by a number of different serotypes. *Shigella sonnei* is the most common cause of shigella infection in the US.

Symptoms include sudden onset of diarrhea, accompanied by fever nausea, and sometimes vomiting and cramps. In severe cases, stool may contain visible blood, mucus, or pus.

The disease is self-limited and complications are rare.

4. **Work restrictions for personnel with Shigella**

Infection control and Employee Health should be notified of personnel with shigella infection.

Health care personnel may not work until they are symptom free for 48 hours after completion of antibiotic therapy.

~~Health care personnel may not work until they have 2 successive negative stool specimens obtained 24 hours apart and taken 48 hours after completion of antibiotic therapy.~~

Commented [s1]: Modified policy from SFGH

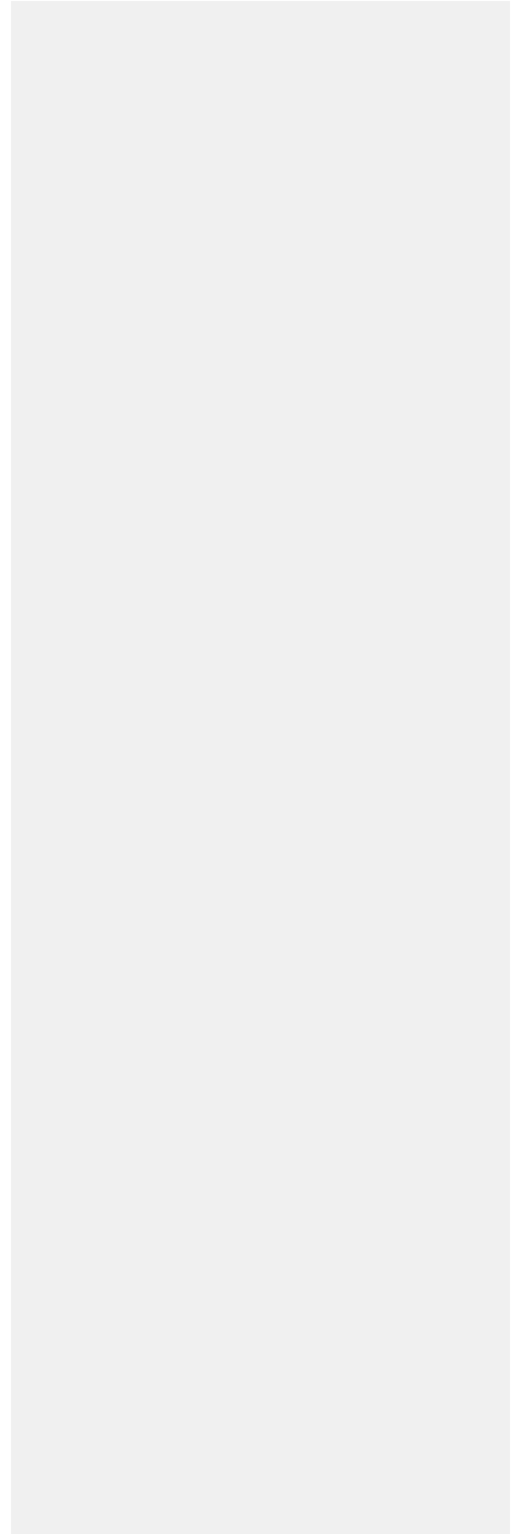
5. **Definition of Shigella Exposure**

Exposures to Shigella among health care personnel are most likely to occur outside of the health care setting, such as if a family member or food provider has been diagnosed with Salmonella.

> Note: Adherence with ~~Body Substance~~Standard Precautions and handwashing guidelines may prevent exposure of personnel from infected residents.
>
> However, in the event a health care worker has had exposure to the feces of a resident diagnosed with shigellosis, contact Infection Control for specific recommendations.

6. **Work restrictions for personnel Exposed to Shigella**

None. Monitor for symptoms.



Policy Number: D28
Revised: ~~November 2005~~August 2009
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Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **STAPH AUREUS SKIN INFECTIONS (INCLUDING IMPETIGO) IN PERSONNEL**

Purpose:

Personnel with bacterial skin lesions such as streptococcal impetigo or other bacterial skin lesions or staphylococcal wound infections are evaluated and managed to minimize the transmission risk to residents and other personnel.

Statement of Policy:

Personnel with impetigo or other skin infections due to *Staphylococcus~~.~~ ~~a~~Aureus* or other bacteria are provided with information and guidance for management.

Procedure:

1. Mode of transmission
Streptococcal ~~I~~"impetigo" and Staphylococcal skin infections occur in adults, but are most common in infants and young children. Hands contaminated with drainage from lesions are the most important cause of transmission. Meticulous hand hygiene and proper adherence to Standard Precautions~~handwashing~~ by personnel prior to performing resident care will prevent resident-to-resident transmission of Staphylococcal infections.

2. Immunization
Not applicable

3. Description of Staphylococcal skin infection:
Lesions on the skin caused by Staphylococcal or other bacteria generally appear as vesicles, which become seropurulent and surrounded by erythema.

Rupture of the pustules can lead to transmission by direct or indirect contact with infectious drainage. Nasal colonization with *Staphylococcus aureus* is not an indication for removing an employee from work or to initiate treatment. Methicillin resistant Staph aureus (MRSA) is not more virulent or contagious than antibiotic sensitive organisms.

Commented [s1]: SFGH

4. Work Restrictions for Personnel with Staphylococcal skin infections

Personnel diagnosed with suspected or confirmed Impetigo, "Staph," or other bacterial skin lesions, the employee or supervisor should contact Infection Control; a determination will be made regarding working in patient care or food service areas.~~may not work in resident care areas or in food service.~~

Commented [s2]: Changed policy from SFGH

Personnel removed from or given restricted duty may return to full work activities when the skin lesions are dry and healed.
~~Personnel may return to work when lesions are dry and healed.~~

Commented [s3]: SFGH

References:

Benenson, A.S. (1995). Control of Communicable Disease Manual.

CDC (1998). Guideline for Infection Control in Health Care Personnel.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **TUBERCULOSIS SCREENING / INFECTION / EXPOSURE IN PERSONNEL**

Purpose:

To reduce the possibility of tuberculosis (TB) exposures in the hospital, the TB status of all personnel at Laguna Honda Hospital (LHH) will be determined at the time of employment and at regularly scheduled screening intervals.

Statement of Policy:

To reduce the possibility of pulmonary tuberculosis (TB) exposures in the facility, the TB status of all personnel is determined at the time of employment and at regularly scheduled screening intervals.

Procedure:

1. Mode of transmission

- TB is transmitted by the inhalation of airborne droplet nuclei.

2. Immunization

- Note: Prior immunization with BCG does not exclude personnel from evaluation for TB infection. A thorough review of symptoms will be done at least annually on all PPD positive personnel. PPD test will be done every 6 months for employees who are permanently assigned to high-risk units such as ~~Admitting,~~ Hospice, ~~AIDS~~ Positive Care Unit and Acute.

3. Descriptions of TB Infection and active TB Disease

TB Infection is indicated by positive PPD of greater than 10 mm, or 5 mm if HIV+ or if there has been close contact with a known active TB case.

Commented [s1]: Check with medical clinic, SFGH is 5 mm

~~TB case.~~

To screen for TB infection upon hire, a PPD is placed and read within 48-72 hours at the Employee Health Service or by a designated surrogate. Measure PPD in mm and ~~record~~ document it in employee health record.

A two-step protocol is required to control for the "booster" phenomenon: If the initial TB skin test is negative, a second skin test is done 7 days after the first PPD.

If an employee can provide record of a negative skin test (5 Tu PPD), placed and read at a recognized health facility within the preceding 12 months, it is accepted as the first test.

Negative PPD at Employment: All employees with the equivalent of 2 negative PPD tests will receive a 5 Tu PPD at least annually, in accordance with the TB Exposure Control Plan.

1. Positive PPD at Employment: If an employee has a positive PPD at the time of employment to LHH, diagnostic evaluation to exclude active TB is performed at SFGH OHS/SF TB Clinic. The evaluation should include:

Commented [s2]: Check with medical clinic

   1. Physical examination
   2. History
   3. Baseline chest x-ray examination
   4. Evaluation for HIV risk factors
   5. Evaluation of preventive therapy
   6. Education in the timely recognition of signs and symptoms of active TB, and need for prompt reporting to the Employee Health Service if symptoms arise.

If treatment or preventive therapy is believed to have been inadequate and/or active TB is found, employment may be deferred until proof of control is documented.

PPD conversion during Employment at LHH: The LHH Employee Health Service will notify the employee health physician for evaluation and/or referral to SF TB Clinic with the following information:

1. CXR

2. Symptom review questionnaire
3. SF TB Referral Form

The employee with a positive PPD will be evaluated by SF TB Clinic and be offered preventive therapy as appropriate.

In subsequent scheduled (at least annual) assessments, the employee is evaluated to exclude active TB and re-educated regarding timely recognition of symptoms and prompt reporting to Employee Health Service.

Employee Health notifies the Infection Control Committee of any PPD conversions.

<u>Volunteers</u>

All new volunteers will receive PPD initial and booster testing done after 1-3 weeks through the LHH Employee Health Service. Volunteers with negative PPDs will have yearly tuberculin (PPD) testing.

Volunteers with negative PPDs who work on high risk units such as Acute, ~~Admitting,~~ Hospice and ~~AIDS ward~~Positive Care Units, will have tuberculin (PPD) testing every six months.

If documented prior positive:
Volunteers with documented past positive PPDs will be evaluated at least annually. The Volunteer Coordinator will submit a list of permanent volunteers to the Employee Health Service annually.

If a volunteer converts:
The Volunteer Coordinator will submit a list of permanent assigned volunteers in the hospital to LHH Employee Health Service. A volunteer with a prior negative PPD who demonstrates, on routine annual testing, induration of greater than or equal to 10 mm must be referred to the SF TB Clinic on Ward 94 at SFGH or private physician with chest x-ray. The appointment must be completed within 2 weeks. The names of any volunteers who convert their skin tests must be immediately given to the Infection Control Coordinator by the LHH Employee Health Service staff so that investigation of a possible source case within the facility can be initiated.

4. Active Pulmonary Tuberculosis Disease

Any employee with signs of active pulmonary TB will be relieved of duty and given immediate referral to the county public health TB clinic or a private physician.

Commented [s3]: NC TB Control Program Policy Manual (Rev. 01/09)

Employee Health Service/TB clinic will report suspected and active cases of TB in LHH campus employees immediately to Infection Control.

Infection Control will confirm the diagnosis, report to the appropriate departments, and initiate a contact investigation.

5. Supervisor and employee responsibility regarding TB symptoms

All workers and their supervisors will be aware of the symptoms of TB, and the skin testing/symptom review TB screening frequency requirements for their unit and/or job classification.

Supervisors will take the responsibility to ensure any worker with a chronic cough (two weeks or greater duration) will be evaluated by employee health.

Special considerations for designated personnel include:

Students: It will be the responsibility of the school, college or university to ensure that prior to affiliation at LHH, TB screening consistent with hospital policy is done.

Medical Staff: It will be the responsibility of the medical staff, at the time of credentialing, to show proof of TB testing/symptom review status consistent with hospital policy.

6. Work restrictions for personnel with suspected or confirmed TB disease

Personnel with suspected or confirmed active pulmonary TB disease may not work within the facility.

Return to work requires certification by the employee health physician that the employee is free from communicable TB.

Documentation must be reviewed and approved by both the Employee Health Service and Infection Control.

7. Definition of TB exposure / Management

Defining exposure to TB is difficult, since TB bacilli travel on air currents and can remain suspended in the air for some time. AT LHH, persons (personnel and residents) are considered "exposed" to TB if they were on the same unit at the same

time as the infected index case for more than 8 hours. See Attachment D–CDHS/CTCA Joint Guidelines.

Commented [s4]: Taken from TB clinic SFDPH, check with TB clinic to get updated guideline

Upon identification of a smear-positive active case of pulmonary TB in an employee or resident not appropriately isolated in high or low level respiratory isolation within the facility, Infection Control will initiate a Contact Investigation of all persons exposed. Smear-negative case exposures will be reviewed, and a contact investigation may be initiated, as decided on a case by case basis.

Follow-up for personnel potentially exposed to TB includes a baseline screen and a follow-up screen at 10 weeks:

- Personnel will have a TB skin test to ensure negativity at exposure.
- Persons with a recent negative TB skin test (within three months prior to exposure) will have that test considered as baseline.

All personnel exposed require a repeat skin test at ten ~~to 12~~ weeks post-exposure:

- Positive reaction signifies converter status (see above protocol for PPD conversion).
- Negative reaction requires no additional follow-up.

8. Work restrictions for personnel with TB Exposure

There are no work restrictions for personnel exposed to TB. Any TB exposures (including those outside of LHH) should be reported to Employee Health Service for appropriate education and follow-up.

References:

Centers for Disease Control and Prevention (1994). Guidelines for Preventing Transmission of Mycobacterium tuberculosis in Health care Facilities.
CDC (1998). Guidelines for Infection Control in Health Care Personnel.
CDAS/CTLA Joint Guidelines.

Laguna Honda Hospital
Infection Control Manual

SECTION D: Personnel Guidelines/Employee Health

TITLE: **VARICELLA AND PERSONNEL**

Purpose:

To reduce the potential for transmission of varicella to both residents and health care workers, Laguna Honda Hospital has implemented a program for varicella.

Statement of Policy:

Laguna Honda Hospital (LHH) has a program to evaluate all personnel, regardless of age, for susceptibility varicella (chicken pox).

Procedure:

1. Mode of transmission
Varicella zoster virus (chicken pox) is transmitted to susceptible persons by direct contact with infected lesions and through inhalation of airborne virus.

NOTE: Susceptible personnel should not provide care for residents with varicella zoster virus (chicken pox or disseminated shingles).

Commented [s1]: SFGH

Primary infection with varicella / chicken pox leads to lifelong immunity.

2. Immunization requirements

Except as otherwise stated in this policy, documentation of varicella immunity is mandatory for all employees. Acceptable proof of varicella immunity include:

- previous history of varicella (chickenpox) infection or reactivated varicella (shingles, zoster)
- positive varicella titer
- proof of two doses of vaccine

Employees not able to provide proof of varicella immunity will have a serum varicella titer drawn.

Newly hired employee who is found to have a negative titer will be offered varicella vaccine according to manufacturers' guidelines because of potential contact with residents suspected or diagnosed with varicella.

All employees receiving vaccine are counseled by Employee Health to monitor themselves for appearance of rash. Any vaccinee who develops rash (equal to or greater than one vesicle) is considered infectious (see Section 3).

Employee shall be given either the consent form ~~(p. 37B and C)~~ or the ~~rejection~~ Declination ~~form~~ form ~~(p. 37D)~~ to sign and shall be advised accordingly. Please see attached consent and ~~rejection~~ declination forms.

Commented [s2]: Consider deleting?? Check with medical clinic

If it is determined by Employee Health or by the employee's designated physician that immunization may be detrimental to the employee's health, the requirements of this policy relating to immunization will be inapplicable until such immunization is found no longer to be detrimental. The nature and duration of the medical exemption must be stated in the employee's health record and must be in accordance with generally accepted medical standards. The health care worker will be counseled regarding varicella, appropriate precautions and the risk of transmission of disease.

Serological titers for vaccinees will not be routinely performed.

3. Description of Varicella Infection

Varicella infection is defined by the following clinical criteria:

- acute onset of diffuse, generalized, papulovesicular rash, without other apparent cause, as reported by a qualified health professional.

Varicella can also be confirmed by lab tests including isolation of varicella virus from a clinical specimen, or significant rise in varicella antibody level by a standard serologic assay, or positive varicella fluorescent antigen test of a scraping of newly opened vesicular lesion.

A person with varicella is infectious and may transmit the disease 2 days before the onset of rash and until all lesions are crusted (usually no more than 5 days after rash onset).

A person with active varicella should be considered infectious for two days prior to the development of rash until all vesicles are dried and crusted.

4. Who should not receive the vaccine

The vaccine is not recommended for anyone who has had a serious allergic reaction to neomycin or gelatin, which are components of the vaccine.

If you are pregnant, you should not receive the vaccine. It is also recommended that pregnancy be avoided for one month following each dose of vaccine.

Others who should not be vaccinated include: anyone who has AIDS or other serious disease of the immune system; anyone being actively treated for any type of cancer; anyone receiving long-term treatment with steroid drugs such as prednisone, hydrocortisone, and dexamethasone; and anyone who has received blood products such as immune globulin, or a transfusion during the past several months.

5. Side Effects of the Vaccine

Not everyone will experience side effects. However, if side effects develop, the most common are pain, redness and swelling at the injection site. Less commonly, a fever greater than 102° and a chickenpox-like rash may be experienced. If vesicles or a rash develops, you may be contagious and close contact with immunocomprised individuals (e.g. persons with AIDS) and pregnant women should be avoided. If you develop a rash, report to your supervisor and the LHH Medical Clinic to determine your ability to return to work. To reduce the risk of Reye's Syndrome, use of salicylates (e.g. aspirin) should be avoided for six weeks following vaccination.

6. Work restrictions for personnel with Varicella

Any health care worker who develops active varicella shall be relieved from work until vesicles are crusted over and no new vesicles have formed. Active varicella includes natural infection or post-vaccine rash.

Infection Control and Employee Health must be notified of any health care workers with varicella.

7. Definition of Varicella Exposure

To ~~be considered~~be considered exposed to varicella, a person must:

- be susceptible to varicella, **and**
- share airspace within the same room for >1 hour with a probable case, or
- have face-to-face contact for 5 minutes or more with a probable case, or
- have any direct skin-to-skin contact with a probable case.

8. Work restrictions for personnel Exposed to Varicella

Documentation will be kept in the employee's health record of any employee lacking protection against varicella. No repeat titers will be drawn unless the employee has been exposed at work or reports an exposure outside of work. In the event of an occupational or personal exposure to varicella, a repeat titer will be drawn only if the previous titer was more than six months prior to the exposure.

Any non-immune health care worker who is exposed to a varicella infection shall be removed from resident contact and the hospital environment on days 10 through 21 post exposure (with day one being counted as the first day of exposure to rash or two days prior to the appearance of a rash in the source).

References:

CDC (1998) Guideline for Infection Control in Health Care Personnel.

CDC (1996). Pilot Testing a National Surveillance System for Hospital Health Care Workers (NASH Program).

Laguna Honda Hospital
Infection Control Manual

SECTION E: Department Policies

TITLE: OCCUPATIONAL THERAPY

Policy:

~~Universal blood and body substance~~Standard precautions ~~(BSI)~~ shall be used to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any ~~patient~~resident is anticipated.

Food shall be stored and prepared in a safe, clean manner.

A. OCCUPATIONAL THERAPY DIRECTOR RESPONSIBILITIES

1. Assess ~~patient~~resident care and safety within the department.

2. Evaluate equipment and products used. Insure proper supplies are available for staff use.

3. Insure proper maintenance and cleaning of all equipment.

4. Periodically review and update policies and procedures relevant to occupational therapy.

5. Submit policies and procedures for situations that may present an infection hazard to the Infection Control Committee for review before adoption and implementation.

6. Provide continuing education classes for staff in the occupational therapy department with documented attendance.

B. STAFF RESPONSIBILITES

1. To be aware of procedures and follow through on their use.

2. To present possible problems to the department head.

3. Staff shall attend annual Infection Control inservice education.

Procedures:

A. ISOLATION PRECAUTIONS

1. The nursing unit shall notify the occupational therapy department when a resident, referred to therapy, is placed in isolation.

2. Residents in isolation shall not be treated in the occupational therapy department, but shall be treated at bedside with the therapist observing required precautions.

3. Residents colonized with resistant organisms are allowed to be treated in occupational therapy department on a case by case basis using appropriate precaution (e.g., diaper, gown).

B. HAND WASHING

1. See ~~Body Substance Isolation~~Standard precautions in Infection Control Manual for detailed handwashing procedures. Hands must be washed with liquid soap and water:

   a. Before and after each ~~patient~~resident contact.

   b. Before handling food.

   c. Before and after using gloves.

2. Liquid soap and paper towels shall be provided at all wash basins.

3. A cut or abrasion on hands shall be covered with gloves or finger cot while working. Persons with draining skin lesions shall not provide ~~patient~~resident care requiring direct ~~patient~~resident contact.

C. SHARPS

Sharps (e.g., disposable razors) shall be placed in puncture-resistant containers for disposal and shall not be reused.

D. LINEN

1. Pillow cases are changed after each ~~patient~~resident.

2. Soiled linen shall be placed in impervious nylon bags.

3. Bags shall be securely closed during transport.

4. Soiled resident clothing shall be wrapped in a clean pad and returned tot eh resident's ward.

E. EQUIPMENT

1. All mat tables and cushions on captains chairs shall be cleaned with a Waxie 700 disinfectant cleaner as needed and at the end of each work day.

2. Wheelchairs and seat cushions shall be cleaned with a Waxie 700 disinfectant cleaner between ~~patient~~residents.

F. HOUSEKEEPING

1. Kitchen, counter tops shall be cleaned daily with a Waxie 700 disinfectant cleaner by department aide.

2. Oven is cleaned as needed.

3. Refrigerator is cleaned weekly.

FOOD PREPARATION, HANDLING AND STORAGE

A. Most food used for food preparation training is obtained from Food Service.

B. When a resident requires training with specific items not available from Food Service (e.g., boxed food; cultural food choices, etc.) items are purchased from a reputable supplier (supermarket).

C. STORAGE OF FOOD

1. Staple food is stored in closed containers, in small amounts.

2. All perishable foods are stored at proper temperatures and temperature records are kept:

    a. fruits, vegetables, dairy products, meats and poultry are stored at temperatures below 41° F

    b. frozen food are stored at temperatures below 0° F

D. Chopping boards used for raw meat shall be washed thoroughly in hot water and detergent; rinsed and taken to main kitchen and washed in industrical dish washer.

E. Chopping boards used for raw meat shall not be used for other foods.

Policy No.: E18
Revised: ~~November 2005~~August 2009

Laguna Honda Hospital
Infection Control Manual

SECTION E: Department Policies

TITLE: SOCIAL SERVICES

Policy:

The Laguna Honda Hospital Department of Social Services will follow the infection control precautions established by the Department of Public Health. Social Services staff will follow the policies approved by the Laguna Honda Infection Control Committee and Medical staff relating to ~~body substance isolation and barrier~~Standard precautions.

Purpose:

To reduce the risk of spreading infection by staff to ~~patient~~residents or by ~~patient~~residents to staff or among one another, the policy is designed to prevent transmission of both detected and undetected agents.

Procedure:

Because medical social work does not typically involve hands-on personal care, the occasions are limited when specific precautions will be necessary. Medical social workers should nevertheless be familiar with the ~~body substance isolation~~Standard precautions guidelines for staff.

HANDWASHING

1. Handwashing with soap and water and using a hand lotion after washing hands to prevent cracking, is the single most effective means of preventing the spread of infection.

2. Hands do not need to be washed when you are simply talking with someone.

3. Hands do need to be washed, for instance, before preparing food, before eating, smoking, before and after ~~patient~~resident contact, after using toilet facilities, or after contact with body substances or soiled substances.

GLOVES

1. Gloves are not needed when you are talking with a ~~patient~~resident.

2. Gloves or finger cots are required if you happen to help a ~~patient~~resident when either you or the ~~patient~~resident have cuts or rashes on your hands or fingers, or the ~~patient~~resident has blood or body fluids on themselves or their clothing. You would not wear the same gloves for more than one ~~patient~~resident, as this can spread infection among ~~patient~~residents and you would wash your hands each time after taking off the gloves.

GOWNS

1. Gowns are not needed when you are talking with most ~~patient~~residents.

2. Gloves or finger cots are required when there is a sign on the ~~patient~~resident's door telling you to talk with the Head Nurse and the Head Nurse tells you a gown is required before entering the room. You would put on a gown if you were assisting a ~~patient~~resident who had urine, feces or blood on him/her.

MASKS

1. Masks are not needed when talking with most ~~patient~~residents.

2. Masks are required when the sign on the ~~patient~~resident's door indicates that you must talk with the Head Nurse and the nurse tells you a mask is required before entering the room. The signs are posted on doors when ~~patient~~residents have an illness, which is know to be spread by the respiratory route, such as tuberculosis or chicken pox. If social workers have questions about whether to wear gloves, masks or gowns when seeing a ~~patient~~resident, they should ask the Head Nurse or Charge Nurse.

<u>NEEDLES</u>

Although social workers should not be handling any sharp objects around ~~patient~~<u>resident</u>s (i.e., scalpels, needles, razor blades, etc.), <u>any</u> sharp instruments or objects must be disposed of carefully in puncture resistant containers. Do not throw them in the wastebasket where someone could get cut throwing away the trash.

SOCIAL SERVICES

POLICY:

The Laguna Honda Hospital Department of Social Services will follow the infection control precautions established by the Department of Public Health. Social Services staff will follow the policies approved by the Laguna Honda Infection Control Committee and Medical staff relating to Standard precautions.

PURPOSE:

To reduce the risk of spreading infection by staff to residents or by residents to staff or among one another, the policy is designed to prevent transmission of both detected and undetected agents.

PROCEDURE:

1. Handwashing with soap and water and using a hand lotion after washing hands to prevent cracking is the single most effective means of preventing the spread of infection.

2. Hands do not need to be washed when you are simply talking with someone.

3. Hands do need to be washed, for instance, before preparing food, before eating, smoking, before and after resident contact, after using toilet facilities, or after contact with body substances or soiled substances.

GLOVES

1. Gloves are not needed when you are talking with a resident.

2. Gloves or finger cots are required if you happen to help a resident when either you or the resident have cuts or rashes on your hands or fingers, or the resident has blood or body fluids on themselves or their clothing. You would not wear the same gloves for more than one resident, as this can spread infection among residents and you would wash your hands each time after taking off the gloves.

GOWNS

1. Gowns are not needed when you are talking with most residents.

2. Gloves or finger cots are required when there is a sign on the resident's door telling you to talk with the Head Nurse and the Head Nurse tells you a gown is required before entering the room. You would put on a gown if you were assisting a resident who had urine, feces or blood on him/her.

MASKS

1. Masks are not needed when talking with most residents.

2. Masks are required when the sign on the resident's door indicates that you must talk with the Head Nurse and the nurse tells you a mask is required before entering the room. The signs are posted on doors when residents have an illness, which is know to be spread by the respiratory route, such as tuberculosis or chicken pox. If social workers have questions about whether to wear gloves, masks or gowns when seeing a resident, they should ask the Head Nurse or Charge Nurse.

NEEDLES

Although social workers should not be handling any sharp objects around residents (i.e., scalpels, needles, razor blades, etc.), any sharp instruments or objects must be disposed of carefully in puncture resistant containers. Do not throw them in the wastebasket where someone could get cut throwing away the trash.

ATTACHMENT:

None

REFERENCE:

None

Most recent review: xx/xx/xx (Year/Month/Day)
Revised: xx/xx/xx
Original adoption: xx/xx/xx

Laguna Honda Hospital
Infection Control Manual

SECTION E: Department Policies

TITLE: REHAB DEPARTMENT SPEECH AND HEARING CLINIC

Policy:

Infection Control guidelines will be followed in the Speech and Hearing Clinic.

Purpose:

To prevent skin and mucous membrane exposure to blood and body fluids and thereby prevent spread of infection to staff and residents by proper use of handwashing and gloves and proper cleansing or disposal of exposed items.

Procedure:

1. Hands must be washed before and after each resident contact.

2. Gloves must be worn when contact with blood, body fluids, secretions or excretions is anticipated.

3. Disposable items are to be properly stored and may not be reused.

4. Non-disposable instruments used orally will be properly sanitized prior to re-use.

5. When food or liquid is given to a resident, any unused portion is to be discarded, unless it is to be used for the same resident within 1-2 days in which case it will be labeled with resident's name, dated and refrigerated.

6. Treatment tables and other communal equipment will be cleaned with a germicidal solution following contact with secretions, excretions, blood or body fluids.

7. Used tissues will be disposed of immediately in a proper waste receptacle.

8. Housekeeping is to be notified immediately in the event of a bowel or bladder accident in the clinic.

Laguna Honda Hospital
Infection Control Manual

SECTION G: Environmental Guidelines

TITLE: **WASTE DISPOSAL, STORAGE AND TRANSPORT ISSUES**

Purpose:

To reduce the likelihood of disease transmission and injury, a waste disposal program has been established which follows specific guidelines and regulations established by the California Department of Health, the Centers for Disease Control and Prevention, the Environmental Protection Agency, the Joint Commission on Accreditation of Healthcare Agencies, and local regulatory agencies.

Statement of Policy:

Laguna Honda Hospital (LHH) has a waste handling policy in place to:

- minimize hazards from infection and/or injury during the collection, storage, processing, transportation, and disposal of waste
- utilize disposal methods that will not pollute air, water, or land.

Guidelines:

Not all waste associated with the delivery of health care is regulated. Regulated medical waste is only that waste which has the potential for disease transmission if not properly managed. Hazardous waste is that waste which has the potential for causing injury if not properly managed.

Procedures:

1. All regulated medical waste other than those designated as "sharps," must be disposed into labeled, red bag-lined containers.

2. All clinical units shall maintain red bag containers in all soiled utility rooms.

3. Red bag containers should only be placed in resident rooms where there is a likelihood that significant amounts of regulated medical waste may be generated, such as with a resident with a liquid volume or post-surgical type drain.

4. All waste at LHH is transported from the clinical units and departments by Environmental Services personnel in a manner consistent with regulatory guidelines.

5. All regulated medical waste is stored in a locked facility prior to removal by a contracted regulated medical waste handler.

6. For specific waste types, refer to the alphabetical listing of all waste types and disposal guidelines below.

ALPHABETICAL LISTING OF WASTE TYPES AND DISPOSAL GUIDELINES
(Examples)

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1. WASTE TYPE: **BIOLOGICALS**
includes serums, vaccines, antigens, antitoxins, and all preparations made from living organisms used in treatment, immunization, or diagnosis

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD**:**
For non-sharps, discard into covered waste container lined with a red bag. For sharps, discard into plastic puncture-resistant "Sharps" container.

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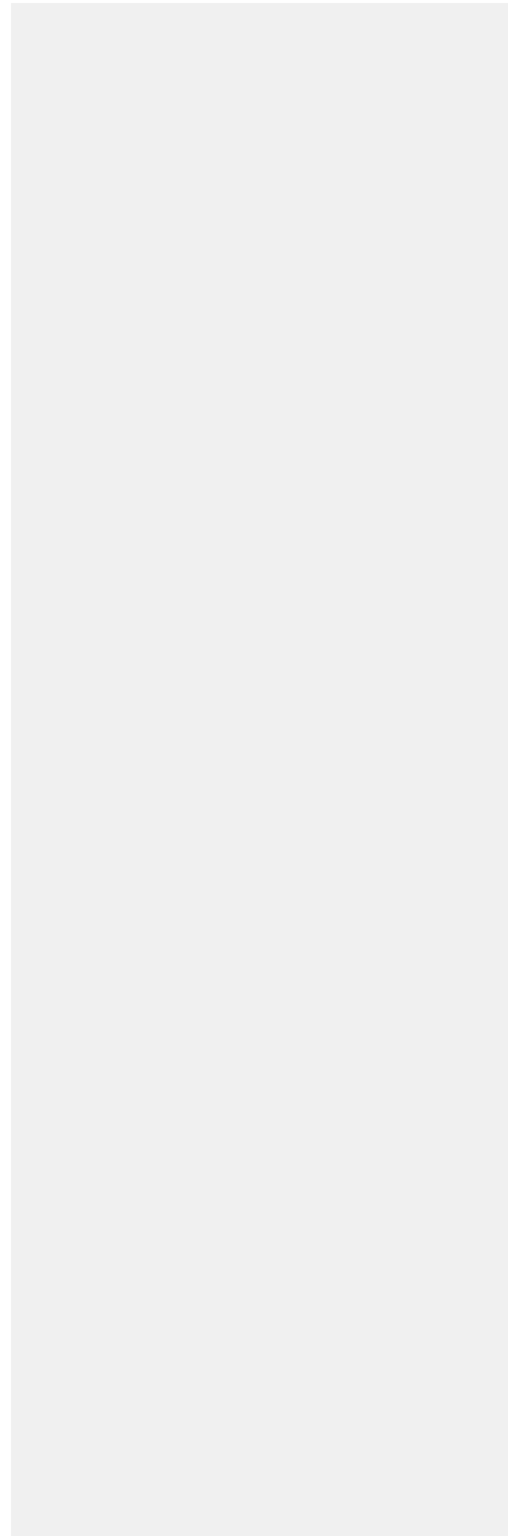
2. WASTE TYPE: **BODY FLUIDS CONSIDERED POTENTIALLY INFECTIOUS**
Includes free flowing

* amniotic fluid
* cerebrospinal fluid
* pericardial fluid
* pleural fluid
* saliva during dental procedures
* semen,
* synovial fluid,
* vaginal secretions, and

* any other body fluid if visibly contaminated with blood and items saturated or visibly dripping with those fluids.



DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD ON CLINICAL UNIT/IN DEPARTMENT:
If free-flowing, and in a container which can be safely handled and closed, discard into red bag container.
If soiled item is saturated or visibly dripping, discard into container lined with a red bag (available in high-use areas, and all dirty utility rooms).

> Note: The determining factor for solid materials to be considered regulated medical waste is if they are saturated to the point of dripping. Individuals are urged not to squeeze any item to determine if it is saturated. Rather, health care workers must use their experience and training to make the determination.

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3. WASTE TYPE: **BLOOD AND BLOOD PRODUCTS**

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:
If free-flowing, and in a container which can be safely handled, discard container lined with a red bag.
If solid item saturated or visibly dripping, discard into cover container lined with a red bag (available in high-use areas), and all dirty utility rooms.

> Note: The determining factor for solid materials to be considered regulated medical waste is if they are saturated to the point of dripping. Individuals are urged not to squeeze any item to determine if it is saturated. Rather, health care workers must use their experience and training to make the determination.

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4. WASTE TYPE: **CHEMOTHERAPY AGENTS**

DISPOSAL CATEGORY: Hazardous Waste

COLLECTION METHOD:

Solid waste is placed into container lined with a red bag. (Sharps items associated with the delivery of chemotherapy are considered both hazardous and regulated medical waste; dispose into designated puncture-resistant "Sharps" container).

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5. WASTE TYPE: **DIAPERS**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Disposed into a container that is lined with a non-red plastic bag.

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6. WASTE TYPE: **DRESSINGS SATURATED/VISIBLY DRIPPING BLOOD**

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:
Discard into container lined with a ~~non-~~red plastic bag.

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7. WASTE TYPE: **FECES**

DISPOSAL CATEGORY: Standard Waste

> Note: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood.

COLLECTION METHOD:
Flush down hopper/toilet into the municipal sewer system.

---

8. WASTE TYPE: **GLOVES**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Discard into waste container lined with a non-red plastic bag.

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9. WASTE TYPE: **DISPOSABLE GOWNS NOT SATURATED WITH BLOOD**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Discard into waste container lined with a non-red plastic bag.

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10. WASTE TYPE: **ANY GOWNS SATURATED WITH BLOOD OR OTHER POTENTIALLY INFECTIOUS BODY FLUID (see list of Body Fluids in #2)**

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:
Discard into covered waste container lined with a red bag.

---

11. WASTE TYPE: **ISOLATION ROOM WASTE**
not considered Regulated Medical Waste except as items fit into specific categories (i.e., Sharps, Blood, Dressings Saturated with Blood or Other Designated Body Fluid)

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Dispose into waste container lines with a clear or white plastic bag, except as isolation waste fits into other categories (i.e., sharps, saturated dressings, etc.)

- OR -

WASTE TYPE: **ISOLATION ROOM WASTE**
if waste derived from resident with highly dangerous communicable diseases, such as Class IV etiologic agents (Ebola or Marburg viruses, Lassa fever, etc.).

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:

Discard into covered waste container lined with a red bag, which has been placed in resident room.

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12. WASTE TYPE: **INSTRUMENTS (DISPOSABLE)**
includes trocars, IV insertion guidewires, and other sharp disposable instruments

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:
Discard into plastic, puncture-resistant "Sharps" container immediately after use.

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13. WASTE TYPE: **IV TUBING AND BAGS NOT VISIBLY CONTAMINATED**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Dispose into waste container lined with a non-red bag.

14.WASTE TYPE: **IV TUBING AND BAGS WITH VISIBLE BLOOD**
or Known to Have Been Contaminated with One of the other Body Fluids Considered Potentially Infectious (see Body Fluids, #2)

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD:
Discard into container lined with a red bag (in the dirty utility room)

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15. WASTE TYPE: **MASKS**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Dispose into waste container lined with a non-red plastic bag.

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16. WASTE TYPE: **PERI/MENSTRUAL PADS**

DISPOSAL CATEGORY: Standard Waste

COLLECTION METHOD:
Dispose into waste container lined with a non-red bag.

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17. WASTE TYPE: **RADIOACTIVE WASTE**

DISPOSAL CATEGORY: Hazardous Waste

COLLECTION METHOD: (Refer to ~~Laboratory~~ Hazardous Drugs Management policy~~ies~~ for detailed instructions)

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18. WASTE TYPE: **SHARPS**
includes hypodermic, intravenous, and other medical needles and attached syringes, scalpel blades, disposable sharp instruments, blood vials, and other glass in contact with infectious agents (slides & cover slips) used in medical care, and also discarded unused sharps

DISPOSAL CATEGORY: **Regulated Medical Waste**

COLLECTION METHOD IN DEPARTMENT:
Discard immediately after use into plastic, puncture-resistant designated "Sharps" container.

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19. WASTE TYPE: **URINE**

DISPOSAL CATEGORY: Standard Waste

> NOTE: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood or other potentially infectious fluid

COLLECTION METHOD:
Flush liquid urine down hopper/toilet into municipal sewer system. For items contaminated with urine, discard into waste container lined with a non-red plastic bag.

References:

NYSDOH "Managing Regulated Medical Waste --- Interpretive Guideline Implementing Revisions to Public Health Law 1389 AA-GG," December 1995.

~~Laguna Honda Hospital~~
~~Infection Control Manual~~

~~SECTION F: Cleaning / Disinfection / Sterilization Guidelines~~

~~TITLE:~~ **~~STORAGE AND TRANSPORT OF CONTAMINATED INSTRUMENTS FROM PATIENT CARE AREAS~~**

~~Purpose:~~

~~Contaminated instruments pose a hazard to healthcare workers and are to be stored and transported from patient care areas according to accepted standards of practice.~~

~~Statement of Policy:~~

~~SFGH has a policy in place for the storage and transportation of contaminated instruments.~~

~~Procedure:~~

1. ~~Contaminated instruments will have gross matter removed from the instruments and associated containers, but will not be terminally washed / disinfected within patient care areas.~~

2. ~~Facility approved puncture resistant containers with lids and locks, identified with the biohazard symbol shall be used. These containers shall be kept in the soiled utility room (nursing units) or, appropriately designated area (segregated from patient care and clean/sterile storage areas). The containers may be used for transport of the instruments to SPD for final processing.~~

4. ~~To prevent drying of organic material, all contaminated instruments will be soaked in a facility approved enzymatic solution.~~

5. ~~After use, place all instruments into the soaking container in a manner that minimizes employee injury and splattering or spraying. Cover securely with lid.~~

6. ~~Containers will be picked up and replaced a minimum of every 24 hours. Areas with a high volume will be picked up more often.~~

7. ~~Prior to transport, containers with solution will be drained. Personnel are required to wear personal protective equipment (gloves, fluid resistant gown, mask and eye protection). Solution is to be drained into the sink.~~

8. ~~Lids are to be securely attached prior to transport.~~

9. ~~Containers are transported on designated carts to SPD for processing.~~

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~~References:~~

~~The Association for the Advancement of Medical Instrumentation, 1996~~

~~APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996~~

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Laguna Honda Hospital
Infection Control Manual

SECTION G: Cleaning / Disinfection / Sterilization Guidelines

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TITLE: **CLEANING OF REUSABLE MEDICAL INSTRUMENTS**

Purpose:

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

Statement of Policy:

Laguna Honda Hospital (LHH) has a policy in place for the cleaning of medical instruments prior to disinfection or sterilization according to accepted standards of practice.

Procedure:

1. Use of Personal Protective Equipment and Attire
In order to minimize the potential transfer of microorganisms from contaminated items to personnel and the environment, the following personal protective equipment must be worn when handling contaminated instruments.

Gloves:
Vinyl or latex gloves are to be worn for handling hand wash delicate microsurgical instruments.

Thicker, more durable gloves are to be worn for handling full trays of instruments, other heavy items, or sharps.

The cuff of the gloves shall be long enough to prevent water from coming over the wrist and into the glove.

Gowns:
Long sleeved, fluid resistant cover gowns are to be worn. Gloves must be pulled up over the gown cuff.

Masks And Eye Protection:
To protect mucous membranes from potential splashes, sprays, or aerosols created during the processing, a fluid resistant mask and eye protection must be worn.

Feet And Leg Protection:
Rubber or plastic boots or disposable shoe covers/leggings combinations are to be worn when processing items where large amounts of fluid will be involved.

Hair:
Hair must be covered with a cap.

2. Pre-Cleaning:

a) Soaking of instruments is required to prevent drying of blood, body fluids or other organic materials on instruments. Situations where soaking is indicated include: heavily soiled items that cannot be rinsed or wiped immediately after use, instances where instruments cannot be cleaned within an hour or two of using, or instruments with lumens or other complex designs that are filled with debris,

b) Contaminated instruments will not be soaked, washed, rinsed, or decontaminated in any resident care area.

c) Tepid water must be used to prevent coagulation of protein materials. The facility approved enzymatic cleaner shall be added to facilitate removal of organic material. NEVER SOAK STAINLESS STEEL OR OTHER METAL INSTRUMENTS IN SALINE NOR USE SODIUM HYPOCHLORITE SOLUTIONS (BLEACH) AS THIS WILL RESULT IN RAPID CORROSION OF THE METAL.

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

3. Cleaning

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

b) Cleaning can be done **manually or mechanically** (by machines). Whenever possible, cleaning shall be done mechanically to reduce the possibility of worker injuries and subsequent exposures.

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

d) Cleaning shall be done using the facility approved enzymatic detergent.

4. Manual Cleaning

a) Handwashing and scrub sinks shall not be used for cleaning instruments.

b) Do not attempt to clean items under running water, for this will create aerosols. Immersible instruments must be cleaned under water. Items that cannot be immersed must be cleaned in a manner that will not produce aerosols, rinsed, and dried according to the instrument manufacturer's instructions.

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

d) After cleaning, instruments are to be thoroughly rinsed to remove debris and detergent residues.

e) Items shall be air dried or manually dried with a cloth prior to final processing.

5. Mechanical Cleaning

a) Types of equipment suitable for mechanical cleaning include ultrasonic cleaners, washer/sanitizer, pasteurization equipment, water/disinfector, and washer/sterilizer.

b) Mechanical cleaners are to be used follow manufacturer's instructions. Only facility approved cleaners/detergents are to be used.

c) Regular preventative maintenance is to be performed according to manufacturer's instructions.

References:

APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996
The Association for the Advancement of Medical Instrumentation
Sterilization Technology for the Health Care Facility; Marimargret Reichert/Aspen Press, 1993

Laguna Honda Hospital
Infection Control Manual

SECTION G: Cleaning / Disinfection / Sterilization Guidelines

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TITLE: **FLASH STERILIZATION**

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Purpose:

Flash sterilization is a special steam sterilization cycle designed for the sterilization of resident care items for immediate use. Flash sterilization can be used for the routine processing of resident care items that cannot be sterilized and stored prior to use. Items processed by means of this cycle must always be used immediately, since sterility assurance cannot be maintained.

Statement of Policy:

Laguna Honda Hospital (LHH) has a policy in place for flash sterilization to be done according to accepted standards of practice.

Procedure:

1. Steam sterilizers used for flash sterilization are to be used and maintained according to the
   manufacturer's written instructions

2. Flash sterilization should only be used when there is insufficient time to process items in the normal fashion (i.e. emergency situations). Flash sterilization is not to be used for reasons of convenience such as an alternative to purchasing additional instrument sets or as a general time-saver.

3. Instruments that are flash sterilized must be used immediately and never stored for later use.
   At LHH, instruments undergoing flash sterilization are never wrapped. Such instruments
   are flash sterilized in enclosed containers to enable transport.

4. Items are to be cleaned prior to flash sterilization.

5. In order to confine the items and protect them from environmental contamination that may be found in route from the sterilizer to the point of use, all items are placed in closed instrument trays with lids (specifically designed for flash sterilization). No porous items such as towels are to be placed in the package.

6. For pre-vacuum sterilizers used for flash sterilization, the following parameters must be met to achieve sterilization:
   a. Must reach a temperature of 270 degrees F.
   b. Minimum exposure time is 3-4 minutes.

7. After completion of the cycle, the trays and the items within will be hot. Personnel must wear sterile gloves and may wear "oven" mitts/ gloves when removing trays from the sterilizer.

8. Use of Chemical Monitors with flash sterilization:
   - Chemical monitors do not verify sterility but verify that the conditions required for the process were met.
   - Sterilization indicators must be placed inside each pack or container. This should change color after the sterilization process and validates that the parameters of the sterilization have been met within the packaged items.
   - **NEVER USE AN ITEM IF THE INDICATOR TAPE OR INDICATORS HAVE NOT CHANGED COLOR.**
   - Chemical integrators will be used when implants are sterilized.

9. Use of Physical Monitors with flash sterilization:
   - Physical monitors must also be used to monitor the sterilization process.
   - The physical monitor for the flash autoclaves is the machine's recording tape.
   - The daily tape from each sterilizer is to be kept with the daily load record.
   - All flashed loads must be written in the sterilizing record daily log.

10. Use of Biological Monitors with flash sterilization:
    - Biological testing validates that sterilization has been achieved.
    - Only biological indicators (spore tests) that have been validated and are recommended for use in monitoring flash sterilization cycles are to be used.
    - Spores of Bacillus stearothermophilus has been approved for this use.
    - Spore testing is to be done on a daily basis, and with EACH IMPLANT load.
    - Once completed, the spore test should be sent to the microbiology lab or incubated on-site according to manufacturer's instructions.

- Results of the spore test should be negative. If test result is positive, refer to policy Biological Monitors, Positive Results
- A spore test control is to be done on a daily basis. The spore test control should be an activated, non-sterilized indicator with the same lot number and manufacturer dates as the test biological indicator used that day. Control tests are to be placed and incubated according to manufacturers' recommendations. Control results should be positive and validate that the spore test used in the sterilizer is from a valid lot and are viable spores.
- Results of the biological and control tests and controls are to be kept with the load records.
- Implants are held until the results of the tests are available.

11. Bowie Dick testing with flash sterilization:
    - Bowie-Dick testing is to be done daily on all pre-vacuum sterilizers used when used for flash sterilization (Generally, the pre vacuum cycle is not used for flash sterilization.)
    - This testing validates the efficacy of the sterilizer's vacuum system.
    - Testing should be performed following the manufacturer's instructions.
    - Records of the Bowie-Dick test are to be kept with the load record in which the test was performed.

12. Load Recordkeeping Requirements for flash sterilization:
    a. contents of each load
    b. time and temperature of exposure cycle
    c. initials of operator
    d. ID number of sterilizer
    e. date and time cycle was run
    f. chemical indicator results
    g. results of Bowie-Dick test (for involved load only)
    h. results of biological monitor and control (for involved load only)
    i. sterilization records must be maintained for a period of three years

13. On a monthly basis, the flash sterilization records should be forwarded to SPD for review
    and storage.

14. Maintenance of Machines used for flash sterilization:
    - Preventative maintenance is to be done a minimum of quarterly; this is monitored by SPD.
    - Repairs are done as needed.

- Records of the preventative maintenance and repairs are to be kept by the contracted maintenance company or engineering. Copies are sent to SPD.

References:

APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996
Association for the Advancement of Medical Instrumentation Standards, 1996
Association of Operating Room Nurses Standards, 1997
CDC Draft Guideline for the Prevention of Surgical Site Infections, 1998

Laguna Honda Hospital
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SECTION G: Cleaning / Disinfection / Sterilization Guidelines

TITLE: **HIGH-LEVEL CHEMICAL DISINFECTION**

Commented [b1]: Outpatient Clinics P&P C4 refers to this policy

Purpose:

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

Statement of Policy:

At Laguna Honda Hospital (LHH), high-level chemical disinfection will be performed by trained and qualified personnel according to accepted standards of practice.

Procedure:

1. Prior to the disinfection process, all devices are to be cleaned (refer to infection control policy, "Cleaning of Reusable Instruments.)"

2. Fluid resistant gowns, gloves, face masks, and eye protection (PPE) must be worn during the cleaning and disinfection procedures.

3. High-level disinfectants must be used. Chemicals must be mixed, stored and used in accordance with manufacturer's recommendations.

   If a 2% glutaraldehyde is used, the following standards of practice must be adhered to:
   a) Once mixed, the solution can be used for a maximum of 14 days. If the glutaraldehyde solution is being used in an auto-disinfection machine, solution must be discarded in 14 days or 40 cycles, whichever come first.
   b) The concentration of the solution must be checked with a test strip daily, each morning prior to use. Tests and results must be documented in a log.

c) Solution is to be discarded at the end of the 14 day period or when test strip indicates solution is not at desired concentration (refer to Environmental Health and Safety for proper disposal).
d) Devices must be immersed in the solution for a minimum of 20 minutes.
e) Glutaraldehyde will only be used in areas with adequate ventilation, preferably with a nearby sink. An air filtration system or vented hood will be used in areas which do not have adequate ventilation.

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

5. If an auto-disinfection machine is used, 0.2 micron filters are to be utilized to filter the tap water prior to rinsing. When the use of sterile or non-filtered water is not possible, tap water rinse should be used and must be followed by an alcohol rinse and forced-air drying.

References:

APIC Guideline for Selection and Use of Disinfectants, 1996
APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996
The Association for the Advancement of Medical Instrumentation

Laguna Honda Hospital
Infection Control Manual

SECTION G: Cleaning / Disinfection / Sterilization Guidelines

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TITLE: **STEAM STERILIZATION STANDARDS**

Commented [b1]: Consider for deletion as more updated similar policy exists in the outpatient clinics manual

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Purpose:

Steam sterilization is one of the processes used at Laguna Honda Hospital (LHH) for the sterilization of critical resident care devices (devices that enter sterile tissue or access the vascular system).

Statement of Policy:

LHH has a policy for steam sterilization to ensure it is performed by trained, qualified personnel according to accepted standards of practice.

Procedure:

1. Steam sterilization is effective is destroying all microbial life including bacterial spores and is the **preferred method** of sterilization for devices that are not heat or moisture sensitive.

2. Prior to the sterilization process, all devices are to be thoroughly cleaned and dried to remove organic material and reduce the bioburden (refer to infection control policy, “Cleaning of Reusable Instruments”).

3. Steam sterilizers are to be used and maintained according to the manufacturer’s written instruction.

4. All items are to be pre-wrapped or packaged according to current AAMI standards.

5. The following parameters must be met to achieve sterilization unless otherwise instructed by manufacturer:

	Exposure Time		
Load Contents	Gravity (250°F)	Gravity (270-274°F)	Prevac (270-274°F)
Wrapped/containerized instrument sets	30	15	4
Wrapped basins	30	15	4
Wrapped textiles	30	25	4

6. After completion of the cycle, the wrapper and the item within will be hot. When possible, allow item to cool. If item needs to be removed before cooling is accomplished, personnel must wear insulated gloves or use towels as "potholders" when removing items from the sterilizer. Items are not handled until completely dry and moved to a cooling rack.

7. Use of Chemical Monitors:
   - Chemical monitors do not verify sterility but verify that the conditions required for the process were met.
   - Indicator tape is to be used to secure package closed. This should change color after the sterilization process is complete and validates the item was exposed to the cycle.
   - Chemical strips must be placed inside each pack or container. This should change color after the sterilization process and validates that the parameters of the sterilization have been met within the packaged items.
   - **NEVER USE AN ITEM IF THE INDICATOR TAPE OR CHEMICAL STRIPS HAVE NOT CHANGED COLOR.**
   - Chemical integrators are placed inside each sterilization container of implant devices instead of the chemical indicators.

8. Use of Physical Monitors:
   - Physical Monitors must also be used to monitor the sterilization process.
   - The physical monitor for the steam autoclaves is the machine recording tape.
   - The daily tape from each sterilizer is to be kept with the daily load records.
   - If steam autoclave does not have recording tape, visually verify the gauges to ensure the perimeters of time and temperature have been met.
   - Documentation of the time and temperature must be noted in the load record-keeping requirements.

9. Use of Biological Monitors:
   - Biological testing validates that sterilization has been achieved.
   - Only biological indicators (spore tests) that have been validated and are recommended for use in monitoring flash sterilization cycles are to be used.
   - Spores of Bacillus stearothermophilus are approved for this use.
   - Spore testing is to be done on a daily basis, and with EVERY load containing implant items or hardware. Once completed, the spore test should be sent to the microbiology lab or incubated in an incubator recommended by the manufacturer. Results of the spore test should be negative. If test result is positive, refer to policy, Biological Monitors, Positive Results.
   - A spore test control is to be done on a daily basis. The spore test control should be an activated, non-sterilized indicator with the same lot number and manufacturer dates as the test biological indicator used that day.
   - Control tests are to be sent to the microbiology lab or incubated in an incubator approved by the manufacturer. Control results should be positive and validate that the spore test used in the sterilizer is from a valid lot and are viable spores.
   - Results of the biological and control tests and controls are to be kept with the load records.

10. Bowie-Dick testing:
   - Bowie-Dick testing is to be done daily on all **pre-vacuum sterilizers** (this is not required for gravity displacement autoclaves).
   - This testing validates the efficacy of the sterilizer's vacuum system.
   - Testing should be performed following the manufacturer's instructions.
   - Records of the Bowie-Dick test are to be kept with the load record in which the test was performed.

11. Leak testing:
   The manufacturer’s leak test is performed weekly for all prevacuum sterilizers.

12. Load record keeping requirements for each steam sterilized load include:
   - contents of each load
   - time and temperature of exposure cycle
   - initials of operator
   - ID number of sterilizer
   - date and time cycle was run
   - chemical indicator results
   - results of Bowie-Dick test (for involved load only)
   - results of biological monitor and control (for involved load only)
   - sterilization records must be maintained on-site for a period of three years.

12. On a monthly basis, all departments performing the steam sterilization should forward records to SPD for review and storage.

13. Maintenance of Steam Sterilizers:

- Preventative maintenance is to be done a minimum of quarterly; this is monitored by SPD.
- Repairs are done as needed.
- Records of the preventative maintenance and repairs are to be kept by the engineering department responsible for maintenance contracts. (Copies should be sent to SPD).

References:

APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996
Association for the Advancement of Medical Instrumentation, 1996
Association of Operating Room Nurses Standards, 1997