

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

<b>1. <u>a. New Hospital-wide Policies and Procedures</u></b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Policy &amp; Procedure Development</b>
LHHPP 20-10	<b>Transfer and Discharge Notification</b>	Created to provide residents with notice of transfer or community discharge as regulated by CMS.
LHHPP 20-11	<b>Laguna Honda Hospital's Response to ZSFG Condition Yellow And Red Alerts</b>	Created to provide a process for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts.
LHHPP 21-16	<b>Overdue Medical Records</b>	Created to inform staff of procedure for retrieval of overdue medical records.
LHHPP 50-09	<b>Capital Asset Administrative Policy</b>	Created to maintain fiscal responsibility of the requesting, procurement, and maintaining of capital assets.
LHHPP 73-15	<b>Ergonomics Programs</b>	Created to provide ergonomic evaluation of tasks and workstations in an effort to prevent injury.
LHPP 75-11	<b>Public Access and Defined Restricted Areas</b>	Created to protect residents, volunteers, visitors and employees, as well as physical structure, supplies and equipment within the hospital and campus setting.
LHPP 75-12	<b>Firearms, Dangerous Weapons and Contraband Policy</b>	Created to provide protocol when encountering persons with a firearm, dangerous weapon and/or contraband.
LHPP 75-13	<b>Forensic Residents/Patients</b>	Created to ensure proper protocol is followed when a patient/resident is in custody.
LHPP 75-14	<b>Safety Support for LHH Patient/Resident</b>	Created to provide procedures when a patient/resident presents a danger to themselves and others, the contract security provider shall be called to provide safety support.
LHPP 75-15	<b>Security Records Retention and Disclosure Policy</b>	Created to establish guidelines for retaining security records.
<b><u>b. New Department Policies and Procedures</u></b>		
<b><i>Department: Medicine</i></b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
MSPP D08-03	<b>Access to Psychiatry Services</b>	Created to provide a consistent, defined, and unified way to access Psychiatry services at LHH.
MSPP D08-06	<b>LH Psychiatry Services</b>	Created to describe the functions, procedures and standards for psychiatric services to LHH patients.

<b>Department: Respiratory Services</b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
RSPP A 17.0	<b>EZ PAP Therapy</b>	Created to safely and effectively administer EZ PAP therapy.
<b>2. <u>a. Revised Hospital-wide Policies and Procedures</u></b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
LHHPP 20-05	<b>Discharge Appeal Process</b>	Revised to add the Director of Social Services or designee to be a responsible party for coordinating the discharge appeal process.
LHHPP 20-09	<b>Short Stay</b>	Revised to include the focused discharge planning procedures for short stay residents during the first 100 days of stay.
LHHPP 21-07	<b>Handling Misfiled Electronic Health Records</b>	Deletion of monthly reports by QM staff to HIS Committee of misfiled EHR.
LHHPP 22-06	<b>Residents' Council</b>	Revised to clarify the role of Residents' Council.
LHHPP 24-18	<b>Resident Locator</b>	Revised to update the functions of the resident locator device.
LHHPP 24-22	<b>Code Green Protocol</b>	Revised to reflect missing person procedures in LHHPP 75-10 Security Services Standard Operating Procedures.
LHHPP 60-01	<b>Performance Improvement Program</b>	Revised to reflect the LHH Quality Assurance Performance Improvement program structure.
LHHPP 60-12	<b>Review of Sentinel Events</b>	Revised to list sentinel events specific to LHH.
LHHPP 70-03	<b>Emergency Response Plan Appendix H5 – Medical Surge</b>	Revised to reflect current procedure in the event of a medical surge.
LHHPP 70-04	<b>Code Silver</b>	Revised to reflect active shooter procedures in LHHPP 75-10 Security Services Standard Operating Procedures.
LHHPP 72-01 B6	<b>Intravascular Device Guidelines</b>	Revised to incorporate latest guidelines for intravascular devices. Reference list was update to refer to nursing and medicine policies.
LHHPP 72-01 B11	<b>Respiratory Care Guidelines</b>	Revised to update procedures to reflect CDC guidelines. References list was updated to reflect all relevant policies.
LHHPP 72-01 B13	<b>Urinary Catheterization Guidelines</b>	Revised to incorporate current CDC guidelines.
LHHPP 72-01 C17	<b>Pediculosis Management</b>	Revised to update procedures for residents or personnel who are infected or exposed to lice.
LHHPP 72-01 C18	<b>Clostridium Difficile Guidelines</b>	Revised to reflect current Clostridium Difficile guidelines.
LHHPP 72-01 C26	<b>Guidelines for Prevention and Control of Tuberculosis</b>	Revised to reflect current Tuberculosis skin test guidelines for health care workers.

LHHPP 72-01 D1	<b>Pre-Employment and Annual Screening of Employees</b>	Revised to combine LHHPP 72-01 D1 and LHHPP 72-01 D2 into one comprehensive policy.
LHHPP 72-01 F1	<b>Construction/Renovation</b>	Revised to reflect the role of Infection Control in renovation/construction projects.
LHHPP 73-01	<b>Injury and Illness Prevention Program (IIPP)</b>	Revised to reflect new department and department manager title, as well as new attachments.
LHHPP 73-09	<b>Respiratory Protection Program (RPP)</b>	Revised to update appendices and reflect Cal-OSHA standards.
LHHPP 75-01	<b>Security Management Plan</b>	Revised to incorporate security management plan process.
LHHPP 75-10	<b>Security Services Standard Operating Procedures</b>	Revised to incorporate 15 new security operating procedure appendices.
<b><i>b. Revised Department Policies and Procedures</i></b>		
<b><i>Department: Nursing</i></b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
NPP D1 2.0	<b>Resident Activities of Daily Living</b>	<ul style="list-style-type: none"> <li>• Under policy #2, clarified that HHA can assist with feeding</li> <li>• Purpose simplified to “promote resident comfort and hygiene”</li> <li>• <b>“Equipment”</b> section removed</li> <li>• “Hygiene &amp; Grooming” title changed to “Personal Hygiene” <ul style="list-style-type: none"> <li>○ Section simplified since we do have an alternative bathing policy</li> </ul> </li> <li>• Included cross referencing to NPP on Elimination, Documentation, and bathing</li> <li>• Simplified “Linen and other personal care items” section to refer to HWPP 72-01 F4 Linen Handling F4</li> <li>• Removed “Range of Motion” from the section titled “Transfer, Ambulation and Range of Motion)</li> </ul>
NPP D1 2.1	<b>Nurse &amp; Resident Call System</b>	<ul style="list-style-type: none"> <li>• Added the following policy to reflect not changing the call light system settings: <ul style="list-style-type: none"> <li>○ “Prior authorization is required from administration to turn off the System or change any settings that can impact resident safety.”</li> </ul> </li> </ul>
NPP D2 3.0	<b>Shower Tilt Chairs</b>	<ul style="list-style-type: none"> <li>• Title changed to “Shower Tilt Chairs (Combi Tilt Chairs).</li> <li>• Operating Guidelines #2 made into “Background.”</li> </ul>

		<ul style="list-style-type: none"> <li>• Reworded Operating Guidelines #1 to state that “As part of orientation, all bedside nursing staff will be trained on how to effectively use the shower chair commode and will be reviewed as needed.”</li> <li>• Removed from criteria for use of shower chair commode. <ul style="list-style-type: none"> <li>○ “Has good trunk control and does not lean sideways or forward.”</li> <li>○ “Does not exhibit involuntary movements.”</li> </ul> </li> <li>• “Resident care plan states that the resident prefers and may use the shower chair commode for bathing.”</li> </ul>
NPP D5 2.0	<b>Stump Care</b>	<ul style="list-style-type: none"> <li>• Removed definition.</li> <li>• Generalized turning and repositioning of resident to per physicians order and as tolerated.</li> <li>• Under procedure, added to keep residual limb flat and extended.</li> <li>• Removed section on limb wrapping as this is no longer done.</li> <li>• Clarified to not apply moisturizers or shave limb while in the process of shrinking.</li> </ul>
NPP D5 5.0	<b>Leg Braces</b>	<ul style="list-style-type: none"> <li>• Changed title to “Application and Management of Braces”</li> <li>• Added policy #3 <ul style="list-style-type: none"> <li>○ “Obtain Physical Therapy or Occupational Therapy consultation for residents who used a brace prior to admission.</li> </ul> </li> <li>• Changed purpose to: <ul style="list-style-type: none"> <li>○ “To support proper application and management of braces.”</li> </ul> </li> <li>• Generalized policy to all types of braces (not just leg brace)</li> <li>• Included consultation with Wound Care Specialist for skin conditions and Rehabilitation Services/ZSFG/or LH Clinic for replacement brace</li> <li>• Included under documentation section for TAR</li> <li>• Added under DNCR: <ul style="list-style-type: none"> <li>○ “Monitor and document any redness, irritation, or breakdown and report skin changes to Licensed Nurse.”</li> </ul> </li> </ul>

<p>NPP E 5.0</p>	<p><b>Enteral Tube Feeding Management</b></p>	<ul style="list-style-type: none"> <li>• Included the following policies: <ul style="list-style-type: none"> <li>○ “Simple balloon gastrostomy tubes will be changed at least every 3 months, and as needed, unless physician order’s otherwise.”</li> <li>○ “A Registered Nurse (RN), who has demonstrated knowledge and skill, may replace a simple dislodged or clogged G-tube (not PEG), unless the physician orders otherwise.</li> </ul> </li> <li>• Changed purpose to: <ul style="list-style-type: none"> <li>○ “All enteral tubes (nasogastric, gastrostomy, &amp; jejunostomy) will be managed in a standardized manner by physicians and nurses to promote patient safety and to reduce the risk of adverse events.”</li> </ul> </li> </ul>
<p>NPP H 4.0</p>	<p><b>Gastric Specimens</b></p>	<ul style="list-style-type: none"> <li>• Added a new section for “Equipment.”</li> <li>• Under Procedure: “Obtaining a gastric sample directly from the stomach.” <ul style="list-style-type: none"> <li>○ Changed from 60 ml to a 35 ml syringe for withdrawing gastric contents.</li> <li>○ Removed “If multiple specimens are required, be certain that N/H tube is taped in place, if it is new.”</li> <li>○ Cross referenced to Laboratory policy and procedure for “Disposition of Specimen.”</li> </ul> </li> <li>• Simplified the Documentation section.</li> </ul>
<p>NPP I 5.0</p>	<p><b>Oxygen Administration</b></p>	<ul style="list-style-type: none"> <li>• New attachment added on oxygen devices and max flow rates.</li> <li>• Simplified policies to generalize emergent situations.</li> <li>• Included oxygen tank security to the policy.</li> <li>• Generalized Purpose: <ul style="list-style-type: none"> <li>○ “To safely administer oxygen therapy.”</li> </ul> </li> <li>• Specified max flow rate for oxygen concentrators to 5 lpm.</li> <li>• Updated “Safety Measures” to reflect current practice of storing oxygen cylinders with valve protection devices in the oxygen cabinet.</li> <li>• Removed under “Preparation of the Resident and Visitors” the section that stated “Residents are to smoke only in designated areas. Remove matches and cigarettes from unsafe smokers.”</li> </ul>

		<ul style="list-style-type: none"> <li>Under "Documentation" section, added "Electronic Health Record."</li> </ul>
NPP J 8.0	<b>Blood Product Administration</b>	<ul style="list-style-type: none"> <li>Added a new section for "Equipment"</li> <li>Policy section reduced to 3 policies.</li> <li>Purpose of the policy changed.</li> <li>In the Procedure section under "Request for Blood from SFGH Blood Bank," RN was included for drawing the blood sample.</li> <li>Blood transfusion scheduling was changed from 0900-1800 to anytime following type &amp; cross match.</li> <li>The policy was also changed to refer to the new building (old policy still referred to the old building).</li> <li>Kathleen working on updating the appendix and adverse reactions to blood transfusions (still pending).</li> </ul>
<b>Department: Volunteer Services</b>		
A 1.0	<b>Volunteer Recruitment Process Life Cycle</b>	Revised to include recognition of an individual or group for the "Special Awards."
VS A3.0	<b>Volunteer Orientation</b>	Revised to include phone and email contact information.
VS A4.0	<b>Volunteer Infection Prevention</b>	Revised to reflect new Tuberculosis skin test guidelines for volunteers.
<b>3. a. Hospital-wide Policies and Procedures for Deletion</b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Deletion</b>
LHHPP 72-01 C15	<b>Residents with Generalized Rashes</b>	This policy and procedures are not necessary per Infection Control Committee
LHHPP 72-01 D2	<b>Annual/Periodic Health Assessment</b>	Incorporated into LHHPP 72-01 D1.
LHHPP 73-12	<b>Annual Employee PPD Testing</b>	Incorporated into the revised LHHPP 72-01 D1 Pre-Employment and Annual Screening of Employees.
<b>b. Department Policies and Procedures for Deletion</b>		
<b>Department: Health Information Services</b>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
HIS 12.03	<b>Overdue Medical Records</b>	Revised to become a hospital-wide policy.

## **TRANSFER AND DISCHARGE NOTIFICATION**

### **POLICY:**

1. Laguna Honda Hospital shall implement Resident room transfer and community discharge notification process that is consistent with State and Federal requirements.
2. Written notice for transfer and discharge shall be provided to the resident, and if known, to the family member or legal representative. The written notice must include the reason(s) for the move, and be in a language and manner that the resident and family member or legal representative understand.
3. Notification and issuance of the notice shall be documented in the medical record.
4. Except in an emergency or the safety of resident(s), facility representatives may not transfer a resident to another room against his or her wishes, unless given prior reasonable written notice as specified in the House Rules.

### **PURPOSE:**

1. To establish consistent process and meet regulatory requirements.

### **PROCEDURE:**

1. Room Transfer Notification
  - a. The Charge Nurse or designee is responsible for notifying the Resident, and if known, the family member or legal representative of room transfers.
  - b. The Charge Nurse shall issue the Transfer notice to the Resident prior to transferring the resident to another room, regardless if the room transfer occurs on the same neighborhood or another neighborhood.
  - c. The Notice is part of the medical record and shall serve as documentation.
  - d. If the Resident expresses concerns regarding the room transfer, efforts shall be made to address the Resident's concerns to the extent possible and shall be documented.
2. Timing of Room Transfer Notification
  - a. A Resident transferring to another room on the same neighborhood shall be provided with one day advance notice.
  - b. A Resident transferring to a room on another neighborhood shall be provided with a 2-day advance notice.

- c. The Resident may agree to room transfers sooner than specified in Procedure 2a or 2b and waive the advance notice requirement.
- d. The Charge Nurse or designee is responsible for documenting the Resident's agreement to room transfers in the above situations.

3. Community Discharge Notification

- a. The Medical Social Worker is responsible for issuing the written notice for community discharges (MR 707 Notice of Proposed Transfer/Discharge).
- b. Issuance of the Notice shall be documented in the medical records.
- c. Refer to LHHPP 20-04 Discharge Planning Procedures #5 and #6 for Resident and family notification for community discharges.

**ATTACHMENT:**

None.

**REFERENCE:**

Code of Federal Regulations (CFR), Title 42, part 483.10 et seq.

Title 42, part 488.424 et seq.

Health and Safety Code sections 1417 et seq.: 1599.1 an 1599.60 et seq.

Welfare and Institutions Code section 14124.7

California Code of Regulations, Title 22 sections 72520, 72527, 73504, and 73523

California Standard Admissions Agreement

LHHPP 20-04 Discharge Planning

Original adoption: 16/07/12 (Year/Month/Day)



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## **LAGUNA HONDA HOSPITAL'S RESPONSE TO ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER (ZSFG) CONDITION YELLOW AND RED ALERTS**

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing quality and timely care and services that are consistent with community and professional standards, and to admit residents that can be safely cared for at the hospital.

### **PURPOSE:**

To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts.

To identify essential communication and coordination to ensure resident safety.

### **ZSFG's DEFINITION:**

"Condition Yellow" – activated by ZSFG when ten (10) or more patients are waiting for beds.

"Condition Red" - activated by ZSFG when only one bed is available in Critical Care with no pending transfers, Post Anesthesia Care Unit (PACU) is at capacity, and more than ten (10) or more patients are waiting for beds at ZSFG.

### **PROCEDURE:**

#### **1. Notification:**

- a. ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO or designee when "Condition Yellow" or "Condition Red" is not resolved within 24 hours of activation.
- b. LHH CEO or designee shall confer with Executive leaders and activate LHH Hospital Incident Command System (HICS) if appropriate.

#### **2. LHH Internal Communication and Planning**

- a. Communication – the designated Incident Commander or designee will contact the following:
  - i. LHH Chief Nursing Officer (CNO) or designee – to ascertain/provide current bed vacancies and bed hold situation

- ii. LHH Patient Flow Coordinator – to provide the current list of ZSFG accepted patients/referrals, and to appropriately identify priority of patients to be admitted as well as anticipate/plan for their care needs.
- iii. LHH Chief Medical Officer or designee – to confer with the Patient Flow Coordinator the appropriate neighborhood assignment and coordinate with Chief of Medicine or designee to plan for the admitting physician assignment.
- iv. LHH Patient Flow Coordinator – Once patients identified and assigned to neighborhoods, Patient Flow Coordinator is responsible for sending a notification to each Resident Care Team (RCT) to inform them of planned admission, including patient's profile. The Coordinator shall obtain from ZFGH the most current medical information, and send referral packet(s) to the neighborhood Nurse Manager or designee.

b. Planning

i. Bed Allocation

- Current Bed Holds may be moved to North Mezzanine vacant beds to accommodate incoming admissions.
  - Keep one (1) General SNF Isolation Room available for clinical need.
  - If acute care bed(s) will be used for SNF resident's admission, approval from California Department of Health Licensing shall be obtained prior to occupancy.
- ii. LHH CEO or designee – shall activate the HICS if appropriate see *LHH HW 70-03 Emergency Response Plan*.
  - iii. Nurse Managers and Directors – shall coordinate with the CNO and Patient Flow Coordinator in carrying out any bed relocation(s) needed, preparing for staffing to implement admissions, and prepare any needed special supplies/equipment, and/or staff education.
  - iv. LHH Chief Operating Officer – shall coordinate with EVS Supervisor terminal cleaning of any resident rooms; Facilities and or Materials Management for any special supplies/equipment needed.
  - v. Director of Quality Management – shall coordinate completion of Utilization Management reviews of residents to be admitted.
  - vi. Director of Admissions and Eligibility – shall plan to register identified resident(s) for admissions for timely processes of face sheets and blue cards.

- vii. Director of Social Service – shall provide planned community discharges for the day and following day to better account LHH bed availability.
- viii. Chief Finance Officer – shall assist in resource allocation or funding, to safely implement admissions.
- ix. Director of Pharmacy Services – shall be informed of any pharmaceutical products that require pre-planning arrangements to ensure timely availability such as TPN.

### **3. External Communication and Coordination**

#### **a. Communication**

- i. LHH CEO or designee shall communicate with ZSFG CEO or designee to confirm number of residents LHH will admit.

#### **b. Coordination**

- i. LHH Patient Flow Coordinator will coordinate with:
  - ZSFG Utilization Management Nurse Manager (UM NM) or designee – to provide names of patients for admission including assigned neighborhood, admitting physician pager number and admitting neighborhood charge nurse phone number.
  - ZSFG Case Manager – confirm time of ambulance pick up
- ii. ZSFG Attending Physician – shall contact LHH Admitting MD for hand off
- iii. ZSFG RN – shall contact LHH Charge Nurse for hand off report
- iv. LHH Admission and Eligibility Department – shall coordinate with ZSFG UM Nurses for any documentation or insurance plan information for the identified patients to be admitted.

### **4. Post Response Debrief**

- a. Incident Commander (if HICS was activated) shall arrange for post HICS debrief with LHH staff involved in the incident response.
- b. LHH Patient Flow Coordinator shall arrange for a debrief with ZSFG UM NM or designee.

### **5. Performance Improvement**

- a. Incident Commander (when HICS is activated) shall identify identified gaps and opportunities, including action plan(s), and report to LHH's Hospital-wide Performance Improvement Planning and Safety Committee (PIPS).
- b. LHH Patient Flow Coordinator shall identify gaps and opportunities, including action plan(s), and report to LHH's Hospital-wide PIPS.

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Original adoption: 16/07/12 (Year/Month/Day)

## **OVERDUE MEDICAL RECORDS**

### **POLICY:**

To ensure the retrieval of all overdue medical records containing protected health information (PHI) from requestors that has not been returned to the Health Information Services (HIS) department within 72 hours.

Or

The retrieval process of overdue medical records shall promptly begin on the 4<sup>th</sup> business day if the medical record is not returned to the Health Information Services (HIS) Department within 72 hours.

### **PURPOSE:**

To assure that all PHI is maintained and easily accessible to the HIS personnel, medical staff and other health providers authorized to access and use PHI.

### **PROCEDURE:**

#### **1. Retrieval Of Medical Records**

- a. The medical records of discharged patients must be received by the HIS within 48 hours of discharge in order for HIS personnel to process the record.
- b. Medical records of discharged patients include the contents of the rack chart, thinned PHI, and any other loose documents.
- c. Discharge records shall not be removed from the unit, from which the patient/resident was discharged, by anyone other than an HIS employee.

#### **2. Chart Requests**

- a. HIS personnel are available, Monday thru Friday, between the hours of 8:00 a.m. - 5:00 p.m., with the exception of legal holidays when HIS is closed.
- b. All medical records requested and delivered from HIS must be returned within 72 hours.

#### **3. Overdue Medical Records**

- a. HIS will run an Overdue List report in the Chart Locator Module of the Nuance System on a daily basis to identify records out to requestors beyond 72 hours.
- b. HIS will contact the requestor, identified on the report, and state that the record must be returned to HIS or the record will be picked up by HIS personnel.
- c. HIS shall perform a chart sweep on each unit to pick-up all overdue medical records and locate missing records.
- d. If the requestor fails to return the record(s) and are not located on the units, an HIS employee shall complete the HIS Department Overdue Medical Records Form.
- e. If on the fourth day after the record(s) was due to be returned to HIS and the medical record(s) has/have not been returned/retrieved, an email will be sent to the last requestor on the Overdue List report informing the requestor medical records are overdue for return to the HIS department. This information will be documented on the HIS Overdue Medical Records Form and provided to HIS Management. The HIS staff will be alerted to check the units for the overdue medical records(s) and report back to HIS Management.
- f. On day five that the medical record(s) has/have not been returned/retrieved, the HIS employee shall complete the HIS Missing Record Form and submit the Form to HIS Management. HIS Management shall inform the Privacy Officer and the Quality Management Director regarding the missing record(s) and complete an Unusual Occurrence (UO) report. The HIS staff shall be alerted to check the units for the missing record(s) and report back to HIS Management.
- g. If the record(s) are found, the bottom section of the HIS Department Missing Form will be completed with the identification of the person who had possession of the record(s), the department where the record(s) were located and the date.
- h. HIS Management will notify the Privacy Officer and Quality Management Director that the missing record(s) were located.

#### **4. Missing Records**

- a. If the record(s) is/are missing, HIS personnel shall complete the Missing Records Form.
- b. HIS shall call or email the person identified in the Chart Locator System as the most recent requestor who received the record(s).

- c. If the requestor indicates that the records was given to another person, the HIS employee will document the name of the person, and his or her unit/department to retrieve the record(s).
- d. If the record(s) are found, the bottom section of the HIS Department Overdue Form will be completed with the identification of the person who had possession of the record(s), the department where the record(s) were located and the date.
- e. HIS Management shall notify the Privacy Officer and Quality Management Director that the missing record(s) have been located.

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Original adoption: 16/07/12 (Yea/ Month/Day)

## CAPITAL ASSET ADMINISTRATIVE POLICY

### POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) endeavors to ensure that all capital assets support the patient care mission and meet the needs of the requesting department. Capital asset is to be purchased at the most competitive price for the level of technology required and maintained in a manner that ensures safety in its operation, prolongs its useful life, and maximizes its cost-effectiveness.
2. It is the responsibility of the LHH Chief Operating Officer (COO), or designee, to submit annually a LHH Capital Equipment Budget, through DPH budget office, to the Board of Supervisors and the Mayor's Director of Finance.
3. It is the responsibility of the LHH COO, or designee, to submit annual Capital Project requests to the City Capital Planning Committee (CPC) for approval.
4. It is the responsibility of the Department Manager and/or Program Director to identify capital equipment needs, select appropriate equipment, plan for purchase, coordinate staff orientation/training, and prepare unit-level new equipment policies and procedures and other patient safety considerations.

### PURPOSE:

To maintain fiscal responsibility of the requesting, procurement, and maintaining of capital assets.

### DEFINITION:

1. Capital Asset is defined as those items with a useful life of more than one year (normally three years) and cost of \$5,000 (including tax, freight and installation costs) or more per unit and stands alone (i.e., is not an equipment part).

#### Capitalization Threshold:

Class of Asset	Threshold
Land and land improvement	Capitalize all
Infrastructure	\$100,000
Building and building improvements	\$100,000
Leasehold improvements	\$100,000
Construction-In-Progress	\$100,000
Equipment	\$5,000
Intangible (software, easements, etc.)	\$100,000

2. There are three mechanisms for acquisition of capital assets:



- a. DPH/LHH Capital Purchases,
  - b. CCSF Bond Financing, and
  - c. Donated capital assets
3. Capital asset that satisfies one or more of the following criteria is defined as medical equipment:
- a. Equipment to be used for patient life support, resuscitation, or critical monitoring;  
or
  - b. Line powered equipment that is likely to come in contact with patients; or
  - c. Equipment in which failure of or unintentional misuse of presents a serious clinical or physical risk to patients; or
  - d. Equipment for which the user requires assistance of the Medical Department or an outside technical service vendor in order to adequately and readily ascertain correct performance.

## **PROCEDURE:**

### **1. Procedure for requesting Capital Assets**

- a. Annually, in the first quarter of each fiscal year, the COO or designee will distribute updated Capital Equipment Pre-Approval Request Forms to all LHH Department Directors/Managers, complete with instructions for completion, deadline dates for submission of documents, and a projected timeline for the entire Capital Equipment Process.
- b. The Department Manager (with assistance from the Medical Department and /or Materials Management) is responsible for:
  - i. Identifying the need for new equipment and/or equipment replacement,
  - ii. Ensuring that all requested equipment is compatible with existing equipment and is not duplicative, and
  - iii. Submitting the pre-approval request form including the item description, model/style., manufacturer and suggested vendor, unit price, quantity, and total projected costs.
  - iv. The requesting Department shall include a recently dated price quote upon which to base and compare prices. The total projected costs shall be inclusive

of all tax, shipping and handling charges, installation and training costs, and any existing equipment/ system integration costs.

- c. The completed request form is sent to the COO or designee to coordinate the review and prioritization with DPH Facilities Advisory Board (FAB). The additional information to be considered is as follows:
  - i. Estimated useful life of the item;
  - ii. Special Use Requirement (Performance) - Purchaser indicates what makes this equipment sole source. The method of purchase used by the Purchaser may differ if the item is indeed one that no other equipment of its class and kind can provide;
  - iii. Design Features (Operating) – Indicate special operating features directly related to use requirements, and not known to be present in other articles of its class or kind;
  - iv. Attachments and Accessories – Indicate the necessity for accessories or attachments of a special nature not available with other articles of its class or kind; or, if satisfactory results cannot be obtained with similar attachments or accessories available with other articles of its class or kind, please indicate justification;
  - v. Critical Dimensions of Capacities – Explain the necessity by reference to use requirements, and provide for reasonable tolerance where possible;
  - vi. Matching and Inter-membering (Interface) – State the degree of matching and/or inter-membering required. Necessity shall be clearly established if the department desires the identical item requested. The fact that the article is to be used in the same area or for the same purpose as an existing item in use is not sufficient justification for a non-competitive purchase. This is particularly critical when interfacing into existing patient databases (eCW, Invision, ADL, etc.) or patient monitoring systems;
  - vii. Performance, serviceability, safety, compatibility with existing equipment, cost, and ease of operation;
  - viii. Avoiding duplication of already existing equipment, and ability to provide adequate installation and maintenance support; and
  - ix. Compliance with the standards for cord-connected Electrical Equipment.
- d. All requests shall include a thorough Justification Statement that includes the relevance of this equipment to the LHH Strategic Goals.

- e. The COO or Designee, will summarize a prioritized list of all LHH requests for the LHH Executive Administrator Committee for review and approval.
- f. The COO or Designee will subsequently submit the completed Capital Equipment Pre-Approval Requests, price quotes and a summarized priority list to the SFHN Executive Administrators for review and approval of the department wide capital equipment requests. The department Finance Director is responsible for the budget submission of the department wide capital equipment request to the CCSF Controller's Office.
- g. The Controller's Office will submit all citywide department capital equipment requests for review and approval by the Mayor's Budget Office and by the Board of Supervisors.
- h. A preliminary list for the Lease Purchase Equipment will be determined based upon the amount of Bond funding available. The CCSF Director of Public Finance will provide the dollar amount information to the LHH COO or Designee.
- i. A preliminary list for the Capital Purchases will be determined based upon Budget Approval of the Board of Supervisors. Both Lease Purchase and Capital Purchase preliminary lists will be reviewed with the Department Finance Director, the LHH COO or Designee to ensure correct prioritization. The COO will develop a final list for review and approval by the LHH Executive Administrator.
- j. The COO, referencing the Capital Lease Budget information, will prepare a packet for approval by a) the CCSF Controller's Office and b) the CCSF Director of Public Finance. Any adjustments to the list shall be brought to the attention of the appropriate Associate Administrator. After approval, the documents will be submitted to the CCSF Purchaser for acquisition. CCSF Purchasing employs a competitive bidding procedure. Under no circumstances, is any LHH employee to give a verbal or written commitment to purchase equipment of any manufacturer or company until the process is completed. The COO will submit status reports on the budget process upon request, to the CCSF Director of Public Finance and the LHH Executive Administrator.

## **2. Procurement Process**

- a. Upon approval and funding of the Fiscal year's Capital Equipment List by the Mayor and the Board of Supervisors, the COO or designee forwards the list of the LHH Executive Administrator and Executive Committee, along with instructions and timelines for the procurement process.
- b. Department Managers/Directors shall complete purchase requisition forms for each item approved, in order to purchase the article and secure competitive prices. Alternative brands may be considered, and special features that are required shall be indicated in the equipment description.

- c. Department Managers/Directors shall complete all purchase requisition documents and forward the packet to the Budget Manager, who approves it for budget compliance and forwards it to the COO or designee.
  - i. Departments are required to provide information with the purchase requisition on any equipment being traded in, exchange, or discarded. Requisitions that indicate a trade in, etc. may not be processed without supporting documentation.
  - ii. An equipment number shall be assigned by the Material Manager or designee before the PO is created.
  - iii. To notify the Accounting Department for any disposed equipment if its cost is more than \$5,000. The accounting staff in charge will have to write it off from the book.
  - iv. Equipment items leased through the City Finance Corporation belong to the corporation and shall not be disposed of without the approval of the Finance Corporation.
- d. Upon receipt of the purchase requisitions, the LHH Materials Manager or designee reviews the documents for accuracy and completeness and verifies that the equipment is listed on the Hospital's approved Capital Equipment budget.
  - i. The LHH Materials Manager or designee returns all requisitions that lack the respective Associate Administrator approval; these will be rejected and returned to the originating Department.
  - ii. If a Department is submitting a purchase request with a budget exception or substitute item, approval from the LHH Executive Administrator or designee is required before submission.
  - iii. The Manager of Facility Services, Health and Safety, and BME consultant shall approve all equipment purchase requests. The equipment shall meet electrical safety, installation, Health and Safety and facility support requirements.
- e. When the review process has been completed, the Materials Manager or designee prepares all documents for purchase, writes the purchase requisition, updates the database, and forwards all documents to Purchasing.
- f. Materials Management purchased the equipment in accordance with Novation Authority, or Purchasing bids the equipment in accordance with City purchasing policies. Purchasing awards the bid to the vendors who meet all legal requirements.

- g. All equipment purchased by the CCSF is determined by a competitive bid process, either through Novation Purchasing Authority or City Purchasing.
- i. The requesting Department determines the acceptability of any alternate bids selected. This is done after the bidding process has been completed, when the vendor for the requested model or brand is not the low bidder.
  - ii. The requesting Department reviews the proposal from lowest bidder, and if sound reasons exist for rejecting the lowest bids, they shall be started in a cover letter to the Materials Manager for forwarding to CCSF Purchasing.
    - If the reason for rejecting the low bid involves any of the equipment specifications/requirements outlined in Section 1.c. above, the equipment is considered “restrictive”.
    - If restrictive reasons for rejection are given, a revised purchase requisition with more acceptable specifications for re-bidding of the equipment is required. Revised purchase requisitions for rejected bids will require additional processing time and delay purchasing.
- h. Proprietary Items

The following items are approved by the CCSF Purchasing, i.e., the brand name and model selected by the department is the item purchased.

- i. Equipment that shall inter-member with equipment previously purchased
- ii. Parts for equipment and systems now in use
- iii. Machines Machinery
- iv. Prosthetic devices

### **3. Procedure for Receiving Capital Equipment**

- a. A Laguna Honda asset tag with asset ID number shall be attached to the equipment (which costs \$5,000 or more) before returning to the Department purchasing it.
- b. All capital equipment, except for vehicles, shall be received and distributed by LHH Materials Management. It is the responsibility of Materials Management to send completed documentation and authorizations for payment to the Accounting Department with the original invoice. The Hospital Fiscal Operations Manager is responsible for ensuring timely payment to the vendor regardless if the equipment

is Purchased or Lease Purchased. A Lease Purchased item requires coordination with the CCSF Director of Public Finance.

c. City vehicles:

- i. New vehicles acquired will first be delivered to the Central Shop for inspection and tag, thereafter LHH Environmental Services (EVS) will pick up for ownership.
- ii. Upon receipt, LHH EVS representative shall notify the Accounting Department and submit related documents as proof of ownership (VIN, City vehicle number, parking slip, license plate number, etc.)

d. The delivery of all Capital equipment ordered through purchase orders is to be made to the Main Receiving Area. No Deliveries are made directly to various departments.

e. Upon receipt of the equipment, Materials Management forwards the equipment for incoming inspection by either Facilities Management, BME, or Health and Safety. After inspecting and entering the equipment in their inventory records, Facilities Management or BME delivers the equipment to the requesting Department.

f. Capital equipment that can be utilized outside the Hospital environment is held in Materials Management until proper security measures can be identified and implemented by the requesting Department.

#### **4. Donated Capital Assets**

- a. "Capital donations" include any capital asset with a fair market value that meets the City's capitalization threshold. (See Definition section 1. above, or refer to Controller's policy 12.4 Donated Capital Assets Guidelines.)
- b. Departments receiving donated capital assets shall notify the Accounting department for recording the assets in the City's financial system.

#### **5. Training**

- a. For training procedures refer to LHHPP 31-04 Training Staff on Using New Equipment.

#### **6. Inventory of Capital Assets**

- a. Departments are responsible for maintaining a system of control over their capital assets and ensuring that the physical location code of each asset is accurately recorded in Fixed Assets Accounting Control System (FAACS). Each piece of equipment is identified by the LHH asset tag of its equipment number.

- b. Annual inventory process
  - i. Accounting staff distributes a list of capital equipment currently in the fixed assets system to each department directors/managers (Project Manager).
  - ii. Department directors/managers will verify the existence, quantity, and location of each asset listed under their names as the Project Manager.
  - iii. Department directors/managers will make corrections to the list, if necessary, to reflect the actual location of the equipment.
  - iv. Department directors/managers will fill out the inventory section of the capital equipment list including disposal information, sign to certify the completion of inventory, and return the list to the Accounting Department.
- c. Disposal: Refer to LHHPP 35-04 Disposal of Hospital Property.
- d. Accounting staff will perform random spot-check on the completed inventory list.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 31-02 Hospital Equipment and Supplies Budget and Procurement

LHHPP 31-04 Training Staff on Using New Equipment

LHHPP 35-04 Disposal of Hospital Property

LHHPP 45-03 Donations

City and County of San Francisco – Fixed Assets Definitions and Guidelines (October 2013)

CCSF Controller’s Accounting Policies & Procedures – 10.3 Asset Management

CCSF Controller’s Accounting Policies & Procedures – 12.4 Donated Capital Assets Guidelines

Original adoption: 16/07/12 (Year, Month, Day)

## **ERGONOMICS PROGRAM**

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to preventing workplace injury and illness by minimizing the stress, strain, and discomfort associated with ill-fitting equipment and tools, and non-neutral postures in the performance of all duties including office work, materials handling, resident handling, and repetitive tasks.

### **PURPOSE:**

1. To implement procedures for ergonomic evaluation of tasks and workstations and for provision of appropriate equipment and tools designed to fit the task and the individual employee in an effort to prevent injury.
2. To implement procedures for collaboration with the EEO Office to reasonably accommodate the needs of employees with recognized disabilities or injuries by providing customized equipment that removes restrictions on their ability to perform their work safely.

### **DEFINITION:**

**Ergonomics** is the field of study that seeks to fit the job to the person, rather than the person to the job. This is achieved through the evaluation and design of workplaces, environments, job tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

### **PROCEDURE:**

#### **1. Standard Furniture, Equipment, and Tools**

- a. All Laguna Honda employees will be provided with furniture, equipment, and tools that are appropriate for the work they are performing.
- b. Standard computer workstations provided to employees shall be adjustable or fitted to the size of the employee in accordance with the DPH Ergonomic Workstation Policy (OCS8).
- c. Standard task chairs will be an appropriate size for the employee.
- d. Telephone headsets will be provided as standard equipment to all employees who are required to use their hands for other tasks while on the telephone for more than one hour per day and who are not able to use a speaker phone without disturbing other employees or violating privacy requirements. These



headsets will be wireless if the employee is required to get up and move away from their workstation while on the telephone.

- e. Equipment and furniture that is shared by more than one employee will be adjustable to accommodate all employees who use it.
- f. New standard equipment or tools that are purchased by any department in an effort to improve ergonomics will be selected with input from the Laguna Honda Department of Workplace Safety and Emergency Management (WSEM).

## **2. Ergonomic Training and Educational Resources**

- a. Beginning in 2017, all employees will attend a basic ergonomics class specific to their job class. New employees will attend as part of their health and safety orientation and current employees will be scheduled to attend throughout the year.
- b. After the initial training, employees may attend a class held for orientation if they would like a refresher.
- c. Employees who spend a majority of their workday at a desk and officed are recommended to refer to the DPH OSH Section's web page on ergonomics for more extensive information and resources.  
<http://dphnet.dph.sf.ca.us/node/535>

## **3. Ergonomic Evaluations and Control Recommendations**

- a. Any employee may request an ergonomic evaluation from the WSEM for any of the following reasons:
  - i. The employee is not sure how to adjust their furniture or equipment, or it does not fit properly.
  - ii. The employee is experiencing pain and/or discomfort associated with work and would like to take action to prevent an injury.
  - iii. An employee or supervisor thinks that a task or series of tasks seems hazardous due to repetition or awkward postures and would like assistance in evaluating and controlling the hazard.
- b. WSEM will schedule an evaluation as soon as possible after receiving a request by phone or email.
- c. WSEM will provide recommendations to both the employee and their supervisor following the evaluation.

- d. If WSEM determines that a hazard would be best controlled with new furniture, equipment, or tools, these will be procured according to procedure 6.

#### **4. Musculoskeletal Injury Associated with Repetition or Awkward Posture Work**

- a. If an employee has an injury or pain associated with performing a task at work, the employee will report the injury to their supervisor and should seek medical attention from one of the workers' compensation designated clinics in accordance with the Laguna Honda Injury and Illness Prevention Program 73-01.
- b. A medical provider may request a workplace ergonomic evaluation as part of their evaluation and treatment of musculoskeletal injury. This will be scheduled with a consultant by the workers' compensation claims adjuster. Do not request an ergonomic evaluation from WSEM for an injury with an open workers' compensation claim.
- c. Any furniture, equipment, or tools recommended by the consultant will be provided through the workers' compensation claims adjuster.

#### **5. Permanent or Temporary Disabilities Requiring Accommodation**

- a. Employees who require additional accommodation beyond having properly fitted and adjusted furniture, equipment, and tools due to medical conditions or disabilities that are not a result of workplace injury must submit an Employee Reasonable Accommodation Request Form available from DHR.
- b. Employees and their Supervisors will work with the ADA Coordinator and the employee's medical provider to determine exactly what accommodation is appropriate.
- c. If the recommended accommodation includes purchasing specialized or custom furniture, equipment, or tools, these will be provided according to procedure 6.

#### **6. Purchase and Installation of Furniture, Equipment, and Tools**

- a. New or replacement standard office furniture (including adjustable table, chair, and keyboard tray), computers, telephone headsets, and hand tools required for job tasks will be provided by the employee's department in accordance with Materials Management and IT policies.
- b. WSEM will provide furniture, equipment, and tools deemed necessary as a result of a WSEM ergonomic evaluation.
- c. WSEM will place all work requests for installation of equipment provided by them, except for telephone headsets.

- d. Department Managers are responsible for submitting a telephone work request for installation of telephone headsets.
- e. Department Managers may choose to purchase office supplies, such as wrist rests and document holders, to improve the comfort of their employees, but are discouraged from purchasing specialized equipment or tools without consulting WSEM.

**ATTACHMENT:**

None.

**REFERENCE:**

73-01 Laguna Honda Injury and Illness Prevention Program  
OCS8 DPH Ergonomic Workstation Policy

Original adoption: 16/07/12 (Year/Month/Day)

## **PUBLIC ACCESS AND DEFINED RESTRICTED AREAS**

### **POLICY:**

Public access is available, except in defined restricted areas, at the Laguna Honda Hospital and Rehabilitation Center (LHH) campus.

### **PURPOSE:**

To protect residents, volunteers, visitors and employees, as well as physical structure, supplies and equipment within the hospital and campus setting.

### **PROCEDURE:**

1. The following persons have public access to the hospital:
  - a. Staff performing work on regularly scheduled shifts.
  - b. If greater than one hour before or after assigned work hours, employee shall first report to the shift supervisor and declare the purpose, place and duration of the visit.
  - c. No specific permission is required to visit the Human Resources or Payroll offices during normal business hours.
2. The following persons have restricted public access to the hospital:
  - a. Current admitted residents with assigned neighborhoods and their approved visitors.
  - b. Refer to LHHPP 24-07 Visiting Hours for approved access to LHH.
  - c. Drop-in visitors shall be provided with public access information by the security contract provider. During business hours of 8:00 a.m. and 5:00 p.m. drop-in visitors shall be directed to the Administration office for further assistance.
  - d. Volunteers making contributions to specific department or have program assignments.
  - e. Vendors and/or other LHH partners with an appointment for official business with a supervisor.
3. Defined restricted areas without public access include floors:
  - a. Second floor service area corridor connecting new building and Administration building.

- b. Floors six, seven and eight in the Administration building.
- 4. Staff shall not interfere with anyone's presence, but immediately report the presence of anyone who seems not to fit into the above categories to the security contract provider. Include location, direction headed, and description.
- 5. Staff shall not authorize a vendor in the hospital without a prearranged appointment with a department head. No one may sell items to residents or staff without the explicit written authorization of the Executive Administrator or designee. Staff shall report the presence of sighted vendors to the security contract provider who shall determine whether the vendor is authorized.
- 6. The security contract provider shall record the name and address of any offender and provide escort from the premises or to the San Francisco Police Department. This procedure applies to employee offenders as well as others; each incident shall be reported to the respective department head.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 24-07 Visiting Hours

LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year/Month/Day)

## **FIREARMS, DANGEROUS WEAPONS AND CONTRABAND POLICY**

### **POLICY:**

All persons entering Laguna Honda Hospital and Rehabilitation Center (LHH) premises who have in their possession a weapon of any kind, shall surrender the weapon to the contract security provider, or take the weapon out of the building or away from the individual.

### **PURPOSE:**

The purpose of this policy is to provide protocol when encountering persons with a firearm, dangerous weapon and/or contraband.

### **DEFINITIONS**

1. Possess – To have physical possession or control of, either on the person, in a desk, locker, cabinet, briefcase or other container, or in a vehicle.
2. Firearm – An instrument from which a projectile, powered by an explosive charge, may be fired which can readily create the risk of death or other serious physical injury.
3. Dangerous Weapon – Any explosive device; electric or electronically powered weapon; a baton, blackjack, sap, billy, sap glove, nightstick, metal knuckles or chukka sticks; any sharp-edged instrument which by its design and purpose is intended for use as a weapon; any instrument which fires a projectile by other than an explosive charge and can readily cause physical injury.
  - a. Weapons also include any instrument, article or substance which, under the circumstances in which it is used or threatened to be used, is capable of causing physical injury or death.
4. Serious Physical Injury – A physical injury, which directly creates a substantial risk of death or which causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of anybody organ.
5. Contraband – Goods which under normal circumstances are illegal to possess e.g., marijuana, cocaine, any unidentifiable substances, syringes, pipes, etc.
6. Rendered Safe – Completely unloading, closing or deactivating the weapon.

### **PROCEDURE:**

#### **1. Firearm/Dangerous Weapon Procedure**

##### **a. Notification Process**

- i. Any employee who has knowledge that a firearm or dangerous weapon is present on LHH premises shall notify the contract security provider immediately.
- ii. Provide as much information as possible including, the reporting person's name, department, location, and description of the subject believed to be in possession of the weapon.

**b. Response Procedure**

- i. The contract security provider staff shall investigate the report of firearms, dangerous weapons and/or contrabands on the premises.
- ii. The contract security provider shall activate the Significant Event Notification Procedure as necessary.
- iii. All persons entering LHH premises who have in their possession a weapon of any kind, shall surrender the weapon to the contract security provider, or take the weapon out of the building or away from the individual.
- iv. Weapons turned over to the contract security provider shall be secured in accordance with the contract security provider's operation procedure.
- v. Should the person in possession of a weapon, with no valid reason to retain the weapon, refuse to surrender it, upon notifying the contract security provider, the contract security provider staff shall respond in accordance to their operation procedure.
- vi. Should a person's physical condition preclude a voluntary relinquishment, i.e., unconscious, heavily sedated, etc. and they are found to be in possession of a weapon; the contract security provider shall be called to confiscate the weapon and follow their process for rendering the weapon safe, and securing in the weapon. The owner shall be advised of these actions as soon as their condition allows.
- vii. All persons who are not authorized to carry a concealed firearms are in violation of the California Penal Code.
- viii. When the person carrying a weapon is an employee, in addition to the contract security provider, the Department Manager, the DPH Director of Security, Executive Administrator, and Human Resources, shall be notified immediately.
  - Call 911 anytime a weapon is being presented in a life threatening manner.

**c. Investigation and Documentation**

- i. The contract security provider shall investigate, and document all reports of firearms, dangerous weapons, and contraband. The report shall include the following:
  - Description of weapon/contraband
  - Any events occurring before, during, or after the process of weapons or contraband.
  - Disposition of weapon/contraband.
  - Name, addresses, contact information, and description of all parties involved.
  - Witness Statements.
  - Supplemental reports.
  - Required camera footage and photographs.
- ii. Request for criminal reports shall be made to the appropriate law enforcement agency.

**d. Persons Allowed to Carry Weapons on the LHH Campus:**

- i. Duly sworn federal, state and city and county law enforcement.
- ii. On Duty Corrections personnel.
- iii. California Concealed Weapons Permitted Personnel.
- iv. Contracted Security providing executive protection.
- v. On Duty armored car and ATM guards functioning within the scope of their duties.

**e. Law Enforcement Weapons**

- i. Law enforcement officers on active duty are not required to surrender their weapons.
- ii. When off-duty law enforcement officers are visiting a patient or receiving treatment, they are allowed to keep their weapon in public access areas only; weapons will not be allowed in treatment areas.



- iii. Law enforcement personnel may surrender their weapons and other issued items such as handcuffs, batons and ammunition to their watch-commander or supervising sergeant, or to any other designated person.
- iv. If the law enforcement officer's watch-commander or sergeant is not available, the contract security provider shall follow their process for securing the weapon inside a weapons locker located on premises.
- v. Prior to entering the treatment area, the law enforcement officer in conjunction with the contract security provider shall ensure that the weapon is rendered safe, and the weapon properly secured.
- vi. Upon being discharged or leaving, the contract security provider's staff shall open the weapons locker to allow the officer to retrieve and reload their weapon.

## **2. Contraband Procedure**

### **a. Notification Process**

- i. Any employee who has knowledge that a patient/visitor is in possession of contraband or through the process of inventorying patient/resident property, contraband is determined, the employee shall notify the contract security provider immediately.
- ii. Provide as much information as possible, including reporting person's name, department, location, and description of the subject believed to be in possession of the contraband.
- iii. The employee shall complete the Unusual Occurrence Form (UO) as required.

### **b. Processing Contraband**

- i. Whenever the contract security provider's staff comes into possession of contraband, they shall treat the contraband according to their operating procedure.
- ii. A detailed report shall be completed by the contract security provider's staff.
- iii. Request for criminal reports shall be made to the appropriate law enforcement agency.

### **ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year, Month, Day)

## **FORENSIC RESIDENTS/PATIENTS**

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (LHH) Resident Care Team will work with the contract security provider to provide adequate care to residents/patients in custody.

### **PURPOSE:**

The purpose of this policy is to ensure proper protocol is followed when a resident/patient is in custody.

### **PROCEDURE:**

1. Upon notification by LHH staff of a resident in police custody, the contract security provider will be dispatched to the area. The contract security provider will advise the correctional custodial officer of LLH's organizational structure including the Resident Care Team members, and will provide the correctional custodial officer with the following information:
  - a. Emergency Response procedures.
  - b. Fire safety, including showing the correctional custodial officer(s)/law enforcement officer(s) the emergency exits, fire pull stations and fire extinguishers.
  - c. Universal Precautions.
  - d. Contract Security Provider's Contact Information.
  - e. Shelter-In-Place.
2. The Resident Care Team and/or neighborhood staff will huddle with the custodial officer regarding any concerns that a restraint (handcuffs, shackles, etc.) may hinder treating the resident/patient, or have the potential to cause nerve, muscle or circulatory impairment. In addition, the hospital staff will follow hospital-wide and departmental policies.
3. Residents/patients in custody will be guarded at all times by a custodial/law enforcement officer, including during transport within the facility, by the law enforcement agency/institutions responsible for the resident/patient. In the event the custodial officer is unable to remain with the resident/patient, it will be the responsibility of the contract security provider's staff to guard the resident/patient.
4. No visitors will be allowed except for those authorized by the law enforcement agency/correction agency institution.

5. The correctional custodial officer will be stationed near the bedside, at a location that assures adequate visual contact and supervision.
6. The Resident Care Team and neighborhood staff will take precautions to assure that any potentially dangerous instruments or equipment are inaccessible to the resident/patient in custody.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year, Month, Day)

## **SAFETY SUPPORT FOR LHH PATIENT/RESIDENT**

### **POLICY:**

When it is determined by an appointed medical professional, or when staff have reasonable cause to believe that a patient/resident presents a danger to themselves and others, the contract security provider shall be called to provide safety support.

### **PURPOSE:**

1. It is expected that the contract security provider's staff shall take an active role to support the nursing/medical staff, and assist in controlling any patient/resident that attempts to harm themselves or others. Such support includes:
  - a. Stand-by – assistance is limited to a security presence as a deterrent, or backup to the medical/nursing staff's actions.
  - b. Assist – assistance shall be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a patient. The contract security provider's actions may include taking control of a potentially escalating situation by giving directives/setting limits.
  - c. Physical Intervention – assistance involves the act of physically containing a patient/resident, or assisting the nursing/medical staff with patient/resident restraint. When assisting the nursing/medical staff with restraining the patient/resident, the contract security's provider's role is limited to physically holding the patient, while the nursing/medical staff apply restraints.

### **PROCEDURE:**

1. When the contract security provider has been dispatched to perform any type of patient/resident assist, the officer shall report to the nurse's station and/or location of the event to receive information, and instruction regarding the patient/resident assist.
2. Upon receiving information from the nursing/medical staff, the contract security provider shall use appropriate intervention techniques to restore a safe and secure environment, considering the following:
  - a. The patient/resident is an imminent threat to other patients/residents, visitors and staff
  - b. According to the Code Green policy, the patient is considered "At Risk" for elopement
  - c. The patient is on a psychiatric hold i.e.5150 or 5350 (LPS conservatorship for psychiatric evaluation or treatment)

- d. The patient is awaiting medical treatment
3. Excluding an imminently threatening situation, when conducting any type of safety support, the contract security provider's staff shall enter the patients/resident's room accompanied by nursing/medical staff.
- a. The contract security provider's conversation with the patient/resident shall be limited to setting limits in order to control the patient/resident, in an attempt to support the nursing/medical staff.
4. If during the safety support process, the patient/resident begins to display risk behavior i.e. raising of voice, using profanity, refusal to comply with the nursing/medical staff's direction, or attempt to intimidate—using threatening physical gestures, or communicating threats, the contract security provider shall give verbal directives, to include communicating the consequences of the patient/resident's behavior, in order to control the patient/resident.
- a. At any point during a standby if the person becomes combative, the contract security provider shall take an active role in controlling the patient through physical intervention, according to the contract security provider's operation procedures.
  - b. A patient/resident who is taken into custody by the contract security provider shall be first medically cleared by the hospital medical staff prior to being transported. The contract security provider's staff shall conduct a standby until the patient/resident is medically cleared.
  - c. When the contract security provider is conducting a standby for a patient/resident who is NOT on 5150 or 5350, but the nursing/medical staff's instructions are to monitor the patient/resident due to being "At Risk," the name(s) of the nursing/medical staff shall be included in the contract security provider's incident report.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year, Month, Day)

## **SECURITY RECORDS RETENTION AND DISCLOSURE POLICY**

### **POLICY:**

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to provide a safe, accessible, and effective environment of care. The overall intent of the video surveillance plan is to ensure that staff can access appropriate, and necessary information to fulfill this policy.

### **PURPOSE:**

The purpose of this policy is to establish LHH guidelines for retaining security records, including video surveillance footage, and to describe the process for responding to security record requests.

### **SCOPE:**

This policy applies to all approved video surveillance recording, conducted within the LHH campus.

### **PROCEDURE:**

#### 1. Retention of Records

- a. Video surveillance continuously records activity at the LHH campus.
- b. The camera images are stored on a computer hard drive.
- c. The image data can be retrieved from the host server for up to one year.
- d. After a 60-day period, analog camera images transition from high resolution to low resolution.

#### 2. Disclosure of Records

- a. Security records request made from parties outside of DPH require that a written public records request, third party request/subpoena for security records, including video surveillance footage is made through the DPH Information Office.
  - i. To process a public records request for video surveillance footage, the following information shall be provided:
    - Date of the Incident
    - Approximate time of the Incident

- Location of the Incident
  - Description of the Incident
- b. The request shall be handled accordingly, taking into consideration the privacy rights of patients and other parties, and the business operations of the facility, among other factors.
- c. Upon being notified by the DPH Information Office, the Director of Security shall submit the records directly to the DPH Information Office/City Attorney.
- d. Security records request are made from within DPH shall be made through the DPH Director of Security.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year, Month, Day)



## ACCESS TO LH PSYCHIATRY SERVICES

### POLICY:

LH Psychiatry shall establish a unified mechanism for access to its comprehensive behavioral health services.

### PURPOSE:

LH Medical Staff and RCTs shall have a consistent, defined, and unified means to access LH Psychiatry services.

### DEFINITIONS:

**LH PSYCHIATRY:** LH Psychiatry is one of the Clinical Services of LH Medical Staff Services as delineated by the LH Medical Staff Bylaws. LH Psychiatry consists of the following categories of staff: Psychiatrists (MDs) and Psychologists (PsyDs/PhDs) who are members of the LH Medical Staff, Psychiatric Social Workers (LCSWs/ASWs), and other registered and/or privileged staff (e.g. registered substance use treatment counselors, privileged behavioral specialists).

**URGENT AND EMERGENT REQUESTS:** These are requests that require immediate response from a LH Psychiatry provider (i.e. call back within 15 minutes). Urgent request requires the resident to be seen ASAP. Emergent request requires the resident to be seen within 24 hours.

**IMMEDIATE RESPONSE:** This means calling back in response to a service request within fifteen (15) minutes.

**ROUTINE REQUESTS:** These are requests that do not need immediate response from a LH Psychiatry provider.

### PROCEDURE:

#### 1. Urgent and Emergent Requests during business days 9AM-5PM:

- a. The primary (or covering) physician shall make the service request by paging 415-327-5130.
- b. Urgent pager call schedule will be posted on the LH Intranet under Psych/Current Calendar.
- c. The primary (or covering) physician shall document the service request through e-Referral (see 3 below).

#### 2. Urgent and Emergent Requests for services outside regular business hours

- a. Business days 5PM-10PM: The on-call physician shall page the on-call psychiatrist.
- b. Weekends and Holidays: The on-call physician shall page the on-call psychiatrist.
- c. The psychiatrist on-call schedule and pager numbers will be posted on the Psych/Current Calendar on the LH Intranet.

### **3. Routine Requests for services**

- a. Routine requests for services shall be submitted through the e-Referral system.
- b. The e-Referral submission shall include a Referral or Consult Question. Other information that can help expedite the referral include:
  - i. Current pertinent symptoms, behaviors and/or functional impairment
  - ii. Current mental health and /or substance use diagnosis
  - iii. Current community-based treatment provider for mental health and/or substance use disorder services
  - iv. History of mental health/substance use diagnosis and treatment
  - v. Brain injury or neurocognitive impairment, and date of last neuropsychological testing, if any
  - vi. Any specific service requests.
  - vii. Notation of need for translator services or other communication resources e.g. non- or limited English speaking, deaf or hearing impairment, assistive communication devices.
- c. A designated LH Psychiatry staff member will review and triage all e-Referral requests for services within one (1) business day of receipt.
  - i. The designated LH Psychiatry triage staff member may, as needed, contact the referring provider for clarifying information.
  - ii. The designated LH Psychiatry triage staff member will assign the case to a provider (or providers) within LH Psychiatry for appropriate assessment and services, including:
    - Psychiatric services
    - Behavioral management services (behavioral consultation, behavioral planning, Laguna Honda Premier Club, Health and Behavioral services)
    - Mental health services
    - Neuropsychological services
    - Substance Treatment And Recovery Services (STARS).
  - iii. The designated LH Psychiatry triage staff will inform the referring physician of the LH Psychiatry provider(s) assigned to the referral by entering in the e-Referral the name(s) of the assigned provider(s).

- d. The LH Psychiatry assigned provider(s) will conduct an Initial Screening/Assessment, based on which he/she may further refer the case to the appropriate services within LH Psychiatry (as listed in above 3c.ii).

**ATTACHMENT:**

None

**REFERENCE:**

MSPP D08-01 Psychiatric Emergencies

Most recent review: 16/03/03 (Year/Month/Day)

Revised: NA

Original adoption: 16/03/03

DRAFT

## LH PSYCHIATRIC SERVICES

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (LH) provides psychiatric services for its residents with behavioral health needs. LH Psychiatric Services providers will conform to the following procedures, protocols and standards when providing care to LH residents.

### PURPOSE:

To describe the functions, procedures and standards for psychiatric services to ensure consistent, reliable and professional provision of psychiatric services to LH residents.

### DEFINITIONS:

**LH PSYCHIATRY:** LH Psychiatry is one of the Clinical Services of LH Medical Staff Services as delineated by the LH Medical Staff Bylaws. LH Psychiatry consists of the following categories of staff: Psychiatrists (MDs) and Psychologists (PsyDs/PhDs) who are members of the LH Medical Staff, Psychiatric Social Workers (LCSWs/ASWs), and other registered and/or privileged staff (e.g. registered substance use treatment counselors, privileged behavioral specialists).

**LH PSYCHIATRIC SERVICES:** Professional services provided by psychiatrists and services provided by psychiatrists and others who are credentialed and privileged to provide psychiatric services at LH.

### PROCEDURE:

#### 1. DESCRIPTION OF SERVICES

- a. Services provided only by psychiatrists:
  - i. Psychiatric Consultation

Psychiatric Consultation consists of a psychiatric assessment, recommendations, and communication of all findings to the referring physician. The consulting psychiatrist shall, if and when clinically necessary, initiate psychiatric medications (including obtaining informed consent). Follow-up consultations at the request of the referring physician may be provided but must meet medical necessity criteria.

Consultation services are time-limited with the purpose of addressing a specific consult question. Clinical needs for ongoing follow up are to be addressed through the mechanisms of ongoing psychiatric medication management (see below) and/or ongoing behavioral health services (by psychiatrists or other providers).

ii. Psychiatric Medication Management

Psychiatric Medication Management consists of the assumption of psychiatric medical care including all necessary treatment, regulatory, compliance, documentation, and billing requirements. Services include but are not limited to: ongoing psychiatric medical assessment; consent for medications; physician medication orders; monitoring for medication response and side effects; gradual dose reduction monitoring and implementation; participation in patient psychiatric treatment plan development; and coordination with primary care physician, RCT, and other LH Psychiatry service providers. Other treatment modalities may include collateral contacts, individual and group psychotherapies, and crisis intervention. Psychiatric Medication Management may be part of Substance Use Disorders treatment.

The decision of whether psychiatric medication management for a particular resident should be assumed by a psychiatrist is made collaboratively between the resident's primary physician and the consulting psychiatrist.

Psychiatrists may provide ongoing psychiatric medication management for residents meeting medical necessity within Primary Care Behavioral Health, Non-specialty Mental Health, Specialty Mental Health and Substance Use Treatment. The psychiatrist shall keep the primary physician informed of the medication treatment plan, the resident's progress, and other pertinent treatment related information.

iii. All Psychiatric Consultation and Psychiatric Medication Management services shall meet medical necessity requirements as described in MSPP D08-02 LH Psychiatry Scope of Service and Organization.

iv. Psychiatric Services may transition between Consultation and Medication Management as clinically indicated.

b. Services provided by psychiatrists and other professionals:

i. Crisis interventions, including 5150 evaluation consisting of evaluation of LH residents who may, due to a mental disorder, present a danger to self, a danger to others or grave disability.

ii. Other Specialty Mental Health services, Non-specialty Mental Health services, Substance Use Treatment services and Primary Care Behavioral Health services as delineated in relevant service and billing privileges and MSPP D08-02, LH Psychiatry Scope of Service and Organization. These may include but are not limited to:

- LPS Conservatorship evaluation and renewal evaluation for LH residents who, due to a mental disorder, may be gravely disabled.

- Capacity determinations to evaluate the ability of LH residents to make informed decisions regarding treatment and care.
- Behavioral consultations and behavioral planning

## **2. PROVIDERS OF LH PSYCHIATRIC SERVICES**

- a. Only LH psychiatrists as identified and defined in LH Psychiatry Scope of Service and Organization shall provide Psychiatric Consultation and Psychiatric Medication Management.
- b. Other services as enumerated in 1.b. above may be provided by other qualified providers of LH Psychiatry.

## **3. ACCESS TO SERVICES**

- a. Access to LH psychiatric services occurs in the following ways:
  - i. Routine services
    - Business days (9AM-5PM): The primary (or covering) physician shall make the service request through e-Referral.
  - ii. Urgent and Emergent services
    - Business days (9AM-5PM): The primary (or covering) physician shall make the service request by paging 415-327-5130.
    - Business days (5PM-10PM): The on-call physician shall page the on-call psychiatrist.
    - Weekends and Holidays: The on-call physician shall page the on-call psychiatrist.
    - The urgent pager and psychiatrist on-call schedule will be posted on the Psych/Current Calendar on the LH Intranet.

See MSPP D08-04 Access to LH Psychiatry Services for more details on service access.

## **4. PRIORITY OF LH PSYCHIATRIC SERVICES**

- a. Recognizing that LH Psychiatry providers are the sole specialists authorized to provide psychiatric services under Specialty Mental Health at LH, LH Psychiatry providers shall give first priority to medically necessary Specialty Mental Health services for LH residents.
- b. LH Psychiatry providers shall give second priority to other psychiatric care including but not limited to Non Specialty Mental Health care, Substance Use Disorder treatment, and Primary Behavioral Health care as clinically indicated and resources allow.

- c. Notwithstanding 3a and 3b above, LH Psychiatry providers shall provide services to all patients meeting medical necessity for service regardless of payer source.

## 5. DOCUMENTATION AND BILLING

All providers of psychiatric services are responsible for understanding and following all documentation and billing standards pertaining to services provided, per regulatory and compliance requirements. All psychiatric services shall be documented in the designated electronic health record.

### ATTACHMENT:

None

### REFERENCES:

1. CBHS Mental Health Staffing Qualifications for Service and Billing Privileges
2. CBHS Mental Health Provider Documentation Manual
3. American Medical Association 1997 Guidelines for the Documentation of Evaluation and Management Services.
4. MSPP D08-01 Psychiatric Emergencies
5. MSPP D08-02 LH Psychiatry Scope of Service and Organization
6. MSPP D08-04 Access to LH Psychiatry Services
7. MSPP D01-05 Psychoactive Medications

Most recent review: 2016/03/03 (Year/Month/Day)

Revised: NA

Original adoption: 16/03/03

## **EZ PAP (Positive Airway Pressure) Therapy**

### **POLICY:**

1. EZ PAP Therapy requires a physician's order stating the frequency.
2. Initiation of EZ PAP Therapy and initial resident/patient education will be delivered by a Respiratory Therapist.
3. Respiratory Therapists and Licensed Nurses may deliver therapy.
4. Resident/patient should not use EZ PAP therapy if experiencing active hemoptysis/epistaxis or nausea.

### **PURPOSE:**

To safely and effectively administer EZ PAP therapy.

### **BACKGROUND/DEFINITION:**

EzPAP (Positive Airway Pressure) is a single-patient-use-only device that creates positive pressure designed to facilitate secretion clearance and increase Lung Functional Residual Capacity (FRC). It is also capable of delivering positive inspiratory pressure support, which may decrease work of breathing by supporting tidal volume. EzPAP delivers a positive pressure throughout the breathing cycle using flow from an air or oxygen flowmeter.

Patient should continue using incentive spirometry between EzPAP therapies.

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### **PROCEDURE:**

#### **Equipment Required.**

- EzPAP device from Respiratory Services Department.
- Oxygen or air flowmeter
- Tissues, emesis basin or wall suction to catch sputum
- Mouthpiece nebulizer if resident/patient is receiving bronchodilator therapy.

1. Verify Physician Order.
2. Practice universal precautions, use appropriate PPE.



3. Explain procedure to resident/patient.
4. Assemble equipment, connect one end of oxygen tubing to air or oxygen flowmeter, connect other end to gas inlet of EzPAP.
5. Connect enclosed pressure manometer tube to port proximal to resident/patient end.
6. When adding a bronchodilator inline: remove mouthpiece and connect nebulizer Tee to EzPAP (2 gas sources are required if meds are delivered). The flow needed to drive the nebulizer will create extra expiratory pressure. Monitor the manometer titrating flows to maintain total pressure of 10 cm H<sub>2</sub>O.
7. Instruct resident/patient to close lips completely over the mouthpiece. Resident may use a nose clip provided by RT if needed.
8. Set flow rate to 5 liters per minute (lpm). Increase flow until expiratory pressure of 10-20 cm H<sub>2</sub>O is achieved.
9. Instruct resident/patient to perform diaphragmatic breathing. Encourage resident/patient to breathe deeply, slowly, and easily against the pressure from the device.
10. Exhale to FRC actively but not forcefully.
11. Exhale for a duration of 3-4 seconds, perform 2-3 huff coughs.
12. Have resident/patient perform 15 to 20 breaths.
13. Repeat for a total of 3 cycles with 1-2 minute rest periods in between.

### **Monitoring**

Monitor/evaluate for response to therapy, such as:

- Resident/patient tolerance of increased work of breathing (WOB)
- Oxygen saturation
- Decrease in sputum production
- Breath sounds
- Hemodynamic instability (increased heart rate and blood pressure).

Hold therapy if experiencing:

- Epistaxis
- Hemoptysis

- Nausea

Notify physician if any complications occur.

#### **Documentation**

1. Respiratory Therapy will document the initial therapy and resident education on the Integrated Progress Note.
2. Licensed Nurses will initial on the Treatment Administration Record (TAR) for each therapy and document EzPAP therapy treatment in the Integrated Progress Note of the resident's chart.
  - Please refer to monitoring criteria above.

#### **Discontinuation Procedures**

1. EZ-PAP orders must be renewed weekly.
2. Physician will evaluate resident for the need of ongoing therapy on a regular basis by using the following criteria:
  - a. Decrease in sputum production.
  - b. Increase aeration noted with auscultation of breath sounds in areas previously decreased.
  - c. Presence of radiological findings consistent with improvement in lung capacity.
  - d. Improvement of Oxygen Saturation.

#### **REFERENCES:**

[Smiths Medical EzPAP® Positive Airway Pressure System - 2016](#)

## **DISCHARGE APPEAL PROCESS**

### **POLICY:**

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) will provide a written discharge notice to the resident, and if known, a family member or legal representative of the resident prior to discharging the resident to the community.
  - a. At a minimum, the written Notice of Proposed Transfer/Discharge (MR 707) will include the following information:
    - i. Name of resident
    - ii. Date resident notified
    - iii. Reason for discharge
    - iv. Effective date of discharge
    - v. Location to which the resident will be discharged
    - vi. A statement that the resident has the right to appeal the discharge action to the State
    - vii. Name, address and telephone number of the State long term care ombudsman
    - viii. Witness signature, and explanation if resident or resident's representative did not sign the written notice.
  - b. For residents with mental illness or developmental disability, the written notice will include the address and telephone number of the agency responsible for the protection and advocacy of the individual.
2. Discharge assessment and planning is initiated on admission and re-assessed at intervals throughout the resident's stay.

### **PURPOSE:**

To preserve the discharge appeal rights of the resident and the discharge rights of the facility.

### **PROCEDURE:**

1. When the Resident Care Team (RCT) identifies that a resident's health has improved sufficiently to allow discharge to the community, and the resident

verbalizes that s/he disagrees with the plan to be discharged to the community and refuses reasonable placement options, the Social Worker shall request for a level of care review by the Utilization Management department.

2. The Utilization Management Nurse ~~will~~shall conduct a review of the resident's medical record and determine if the facility has met the conditions for discharging the resident to the community. A Discharge Plan Review form is available for use to assure that a comprehensive review is carried out.
3. The Utilization Management Nurse will notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge Notice.
4. The resident ~~will~~shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge. The 30 day period may be waived only if appropriate housing has been secured for the resident.
5. The Social Worker must notify the Quality Management Department as soon as s/he is aware that the resident has filed a complaint to contest the discharge.
6. The Quality Management designee will gather pertinent resident information and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.
7. The facility will be notified of a scheduled discharge hearing date and the Quality Management designee or the Director of Social Services or designee shall~~will~~ coordinate with the RCT, Utilization Management Nurse and Deputy City Attorney to prepare oral and written testimony for the discharge hearing to demonstrate compliance with resident discharge planning requirements.
8. The RCT ~~will~~shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.
9. The resident may not be involuntarily discharged from the facility prior to the discharge hearing or issuance of the Decision and Order, but may choose to be voluntarily discharged and s/he can request for assistance with discharge planning arrangements from the RCT.
10. The RCT must clearly document that such discharge planning arrangements were made based on the resident's request.
11. If the resident is voluntarily discharged from the facility, the Quality Management designee is responsible for notifying the California Department of Public Health Office of Regulations and Hearings and the local Licensing and Certification Office.

12. Following the discharge hearing, the State of California will issue a Decision and Order and the facility will proceed with the issued directions contained in the document.

**REFERENCES:**

LHHPP File: 20-04 Discharge Planning

[Discharge Plan Review Form \(posted on the Laguna Honda Intranet\)](#)

Revised: 09/08/31, 16/07/12 (Year/Month/Day)

Original Adoption: 08/04/28

## 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 in under 100 days 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 be discharged from general SNF care Laguna Honda Hospital 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. Patients designated as LSA, LRH, and LHP will continue to be designated as such, and will not be moved to the LSS code.

### 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 and the appropriate course of treatment for the resident and the viability of the resident improving sufficiently for discharge within 100 days.
  - i. The LSS short stay code is used primarily for residents who would otherwise be coded as General SNF (LHG).
  - ii. The four other short stay codes are used for residents on Palliative Care, Positive Care, Rehab, and Respite.
- 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 1 – Day 14: ~~Day of Admission - 14<sup>th</sup> day post admission.~~ Discharge planning for Short Stay residents begins immediately on admission. The following steps must occur between resident's first day of admission and fourteenth day post 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. The Medical Social Worker shall initiate discussion of discharge destination with residents who have decision-making capacity and with the responsible party, if consent is provided by the resident.

~~— Doctor – When possible, the resident's doctor will set a prospective discharge date for the patient. The doctor will record prospective internal discharge date in the care plan section of the resident's chart and LCR so that all care team members have resident's discharge date readily available at all times.~~

~~ii. Nursing – Admitting nurse will initiate discussion of discharge destination and resident's short stay designation with resident or responsible.~~

~~iii.~~ii. Resident Care Team – An initial Resident Care Team Conference ~~will~~ shall be held within 14 days of admission to discuss the resident's goals of care and discharge plan including with family members and or other caregivers, if appropriate. The RCT Care Team ~~will~~ shall establish discuss a tentative discharge date and discuss the meaning of short stay plan ~~designation~~ with the resident and or responsible party at during the first care team Resident Care Conference meeting. -

~~iv.~~iii. Utilization Management – Nursing will affix a sticker ~~in front~~ on the spine of the chart to denote a short stay resident.

- b. Day 15 – Day 45:

- i. Social Services Director and Patient Flow Coordinator – Social Services Director and Patient Flow Coordinator ~~will~~ shall track the short stay resident's progress with discharge planning ~~via hard copy calendar~~ and ~~will~~ notify care team the RCT when ~~patient~~ the resident's length of stay reaches 45 and/or 75 days since admission.

c. Ongoing Discussion of Short Stay Discharge Progress:

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

- Utilization Management – Nurses shall verify that the Hospital Code is correct and reflective of Short Stay designation. Nursing will establish a practice of weekly summaries for short stay residents.
- Resident Care Team – Resident Care Teams shall discuss all “Discharge Ready” (per the Discharge Status Report) residents at thea during the weekly discharge huddle. Resident Care Teams willshall prioritize the discussion of short stay residents first.
- Nurse Manager or designee – Nursing shall establish a routine of completing weekly summaries for short stay residents will verify that the Hospital Code is correct and reflective of Short Stay.

iii. Bi Monthly Hospital-wide Short Stay Huddle:

- This huddle is facilitated by the Director of Social Services and the Utilization Management Nurse or designee, and attended by the Neighborhood’s Nurse Manager or designee and the Social Worker with for residents who have been identified as Short Stay residents.
- The intent of this discussion is to track that residents’ with Short Stay designation- codes are within-onthe track of-with their discharge plan. Any Short Stay resident that is not meeting the planned discharge timeline will be referred to Discharge Performance Improvement Team (PIT) to identify opportunities for improving discharge planning efforts. to look at data and trends to improve processes and the UM Committee.

d. Day 45:

- Social Services Director –The Social Services Director will notify resident care teamthe RCT via email thatwhen the Short Stay resident has reached the 45-day check-in milestone.
- Resident Care Team – At 45 days after admission, Resident Care team willshall assess resident’s discharge barriers to determine if the resident is on track for a timely discharge. If patient-the resident is not on track for timely discharge, Care Teamthe RCT shall -will email the Patient Flow Coordinator to notify her/him about patientregarding the resident’s status, and will-update the care plan to reflect the change. The Care TeamRCT shall -will update the



discharge care plan to mitigate all-identified barriers to discharge and revise the estimated length of stay to 75 days, if appropriate.

- iii. If the patient-resident is likely to reside at Laguna Honda for longer than 100 days, Care Team the RCT shall will follow the steps outlined in this policy's Section 3: Procedure # 3 - Change of Short Stay Codes.

e. Day 75:

- i. Resident Care Team – At 75 days after admission, the Resident Care Team will shall follow the same procedure as at 45-day assessment interval to determine patient's the resident's potential for discharge in less than 100 days.

f. Day 90 – Day 100:

- i. Social Worker – If patient the resident has not discharged within 90 days of admission, the Social Worker, with input from Resident Care Team, will shall email notify the Patient Flow Coordinator and Social Services Director to and provide status updates and progress toward discharge.

### 3. Change of Short Stay Codes

- a. A significant change in the resident's health condition will shall be the only reason for changing a resident's code from Short Stay code to another a general SNF (LHG) 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 shall evaluates each short stay code change request and meets with the resident Resident care Care team 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 who will responsible for update updating the coding code from from a short stay code to LSS to the appropriate code (e.g. LHG for general SNF services or to another short stay, LSS).
- iv. The Director of Social Services will shall notify the Resident Care Team that the resident's discharge plan must change, and the Resident Care Team will

shall update the discharge plan with ~~items~~ interventions to mitigate identified barriers to discharge.

b. Short stay residents who have completed Rehab services (LHR), but ~~is~~ are not ready for discharge to the community may have their short stay code changed to the LSS service code for continued tracking when relocated to a general SNF unit, or upon request of the rehab RCT members, with approval from the Director of Social Services and the Patient Flow Coordinator as described under Procedure 3a (iii).

~~a.c.~~ \_\_\_\_ 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.

~~b.d.~~ \_\_\_\_ Extenuating circumstances within the discharge planning process that are unrelated to the resident's 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.

~~c.e.~~ \_\_\_\_ Residents who are not discharged within 100 days ~~but that and~~ have not had a significant change in health condition warranting a change in hospital service code ~~will shall~~ remain ~~on the~~ with the Short Stay code until discharge.

4. Reports and Metrics: Metrics described below track the effectiveness of discharge planning efforts for residents ~~on having~~ the Short Stay code.

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 shall~~ perform a quarterly analysis of Short Stay residents for identification of learning and improved opportunities. For trend analysis, the following metrics ~~will shall~~ 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 are discharged within 100 days.
- c. Quarterly analysis ~~will~~ shall be performed to support performance improvement projects targeted toward specific sub-populations. Outcomes ~~will~~ shall be reported to both the Community Re-integration Performance Improvement Team and the Utilization Management Committee and ultimately ~~through~~ to the Performance Improvement and Patient Safety (PIPS) committee.

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Revised: ~~16/05/10~~ 16/07/12 (Year, Month, Day)

Original adoption: 16/01/12

## HANDLING MISFILED ELECTRONIC HEALTH RECORDS

### POLICY:

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

### PURPOSE:

To implement a systematic process for handling electronic health record (EHR) errors initiated or entered by clinical staff into the EHR.

### PROCEDURE:

1. Whoever notices that an electronic record/ note has been entered in an incorrect patient/resident record shall complete an Unusual Occurrence (UO) report and provide the following information:
  - a. Date and report type, e.g., "LHH-Neuropsychology note dated 7/8/11";
  - b. Name and MRN of incorrect patient record;
  - c. Name and MRN of correct patient record (if known).
2. Quality Management (QM) staff will route the UO for expedited review to the Health Information Service (HIS) designee, and notify the Information Services (IS) designee.
3. A clinician may contact HIS staff independent of QM's processing of UOs.
4. Laguna Honda QM staff shall notify SFGH Risk Management staff if the error originated at SFGH.
5. HIS staff will confirm the error and request IS staff to remove the erroneous note and place the note into the correct patient record (if possible).
6. If the note has been electronically signed and locked, it cannot be altered in any way, therefore an addendum note must be written to disregard the above erroneous note.
7. Laguna Honda HIS staff shall contact other DPH HIS Directors/Managers if needed to resolve EHR errors originating or impacting other DPH entities.
8. IS staff will then delete the erroneous note from the incorrect patient's/resident's record and place the correct note into the correct patient record (if possible).
9. IS staff will notify QM, HIS and the clinician when Procedure 8 is completed.

~~10. QM staff will provide a monthly report to the Health Information System Committee the status of EHR errors.~~

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Revised: 15/07/14, 16/07/12 (Year/Month/Day)

Original adoption: 12/07/31

## RESIDENTS' COUNCIL

### POLICY:

~~The Activity Therapy Department is primarily responsible for facilitating Residents' Council meetings to ensure that concerns about policy and operational issues that affect resident care and life at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) are addressed.~~ provides residents a forum including space, promotion and coordination to attend in order to ~~te~~ express concerns, issues and needs that may include time without any staff present for joint problem resolution and/or decision making that affect resident care and quality of life.

### PURPOSE:

To provide an effective forum for residents to participate in ~~policy and operational~~ decisions that affect resident care and quality of life at Laguna Honda.

~~1. To assist Residents' Council through their meetings to be an effective voice that promotes the maintenance or enhancement of each resident's quality of life.~~

### PROCEDURE:

1. Hospital staff members are responsible for encouraging and enabling resident participation in Residents' Council meetings. This is done without regard to any resident's culture, religion, sexual orientation, gender identification, disability, age, socioeconomic status, and expressed beliefs or opinions.
2. ~~Meetings of the~~ Residents' Council ~~occur~~ generally occurs monthly each month.
3. Processes and procedures related to the Resident's Council and its meeting is at the discretion of the Residents' Council and may refer to bylaws that residents have created and approved.
4. Staff representation at the Residents' Council meetings and responsibilities related to the Residents' Council are as follows:
  - a. Activity Therapy Supervisor
    - i. Assist Residents' Council officers to fulfill their roles to lead and facilitate Residents' Council meetings.
    - ii. Assist residents to attend Residents' Council meetings to communicate their opinions, issues and/or concerns.
    - iii. Reserve private space for the Residents' Council meetings and facilitate room set-up.

- ~~iv.~~ Post notices of Residents' Council meetings to encourage attendance and participation.
- ~~v.iv.~~ Ensure recording of meeting minutes, which may involve assisting review and revision of minutes by a Residents' Council member.
- ~~v.~~ Maintain three most recent years of Residents' Council records, and proceedings including minutes and correspondence.
- vi. Forward meeting minutes to staff as identified below.
- vii. Facilitate elections of officers as requested by Residents' Council
- b. ~~Executive Assistant to the Executive Representative from Administration or~~
  - i. Acts as the communication liaison between Residents' Council Officers and hospital operational departments ~~hospital staff.~~
  - ii. Responds directly to questions and concerns related to hospital departments, operations and/or administration. ~~Follows up with hospital staff on issues raised at Residents' Council meetings that require a response and coordinates communications from hospital staff to the Residents' Councils.~~
  - iii. Reports to the Executive Administration stion/designee when further action is needed to facilitate and/or address communications.
- ~~c. Executive Administrator or designee (ad. lib)~~
  - ~~i.~~ Reports on items related to hospital operations of interest to the Residents' Council.
  - ~~ii.iv.~~
  - ~~iii.~~ Responds directly to questions and concerns raised by residents during the meeting.

Takes input from residents for consideration during planning and implementation of hospital operations, projects, and initiatives.
- ~~d.c.~~ Nursing Director and/or designee
  - i. Responds directly to questions and concerns related to nursing care or accommodation of needs raised by residents during the meeting.
  - ii. Takes input from residents and for consideration during clinical and operational decision making of the Nursing Division.

5. Third parties (staff, not identified as staff representation, or non-residents) wishing to attend a Residents' Council meeting and address Residents' Council members must obtain express permission from the Residents' Council President prior to the meeting date.
6. Activity Therapy Supervisor distributes Minutes of the Residents' Council no later than ~~two~~one weeks after the meeting, to the following:
  - a. Residents' Council Officers
  - b. Executive Committee
  - c. Department Managers
  - d. Directors of Nursing and Nurse Managers
  - e. Activity Therapists
  - ~~f. Medical Social Workers~~
7. The Residents' Council may ~~have questions or concerns and~~ request that an issue be addressed by hospital staff. The Residents' Council meeting minutes will designate the Hospital staff responsible for the area of resident concern and the request for response.
8. Hospital staff should address issues raised in the Residents' Council Meeting Minutes by either submitting a letter or asking the council for time on the next month's meeting agenda. ~~by completing the Residents' Council Response Form, attached to this policy, and submitting the completed form to the Executive Assistant no later than 14 days from the date the Minutes are distributed.~~
9. Activity Therapy staff may review Residents' Council minutes with residents on their assigned units at the neighborhood community meetings, ~~and~~ during hospital-wide cultural and social group activities, as appropriate.
10. A copy of the Residents' Council Minutes is made available to any resident upon request to the Activity Therapist.

**ATTACHMENT:**

None.

**REFERENCE:**

~~None~~

Health and Safety Code Sections 1569.31 and 1569.312  
Main Building Resident Council Bylaws

Revised: 09/08/14, 10/04/27, 16/07/12 (Year/Month/Day)



Original adoption: 07/12/18

## RESIDENT LOCATOR SYSTEM

### POLICY:

Laguna Honda Resident Care Teams (RCT) may use a tracking system (also called locator system) to reduce risk of loss, injury and other adverse outcomes for residents.

### PURPOSE:

Laguna Honda Hospital and Rehabilitation Center's goal is to provide care in the least restrictive setting. The use of the resident locator system is intended to ensure safety and maximize resident's freedom.

### BACKGROUND:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) has installed in its new building a Wi-Fi based tracking system (brand named AeroScout®). A tag worn by a resident regularly signals its presence. Standard Wi-Fi access points detect the signal, which system software uses to determine the tag's location and to associate it with the resident's name, MR#, and primary language. Special detectors, called exciters, are installed in critical locations (including exits from the Laguna Honda neighborhoods, fire doors, main hospital exits, entrance to swimming pool). These cause a nearby tag to signal its presence. For any resident wearing a tag, the authorized area for wandering is determined and pre-programmed. If the resident attempts to go into an unauthorized location (e.g., an elopement risk resident exits a fire door), the system transmits alerts to predetermined recipients, so that staff can intervene.

### PROCEDURE:

#### 1. Resident Assessment:

- a. At every assessment (admission, re-admission, quarterly, annual, significant change of condition, or other as needed), the RCT will assess each resident for wandering/elopement risk.
- b. If the RCT determines the resident is cognitively impaired and has prior history of, or new episode of, wandering, elopement, or inability to return to the neighborhood without help, the RCT will discuss the risks and benefits of monitoring the resident with the locator system.
- c. If deciding to use the locator system, the RCT will identify the resident's risk category as one of the following:
  - i. Not safe to leave the neighborhood unescorted (~~risk-resident~~ category is "Unauthorized").

- ~~ii. Safe to walk unescorted through Laguna Honda buildings and contained gardens, but not safe to exit the front doors of the building unescorted (risk resident category is "Indoor Only/Indoor Only").~~
- ~~ii. Safe to walk unescorted through inside and outside of Laguna Honda buildings (resident category is "Full Access").~~
- d. The RCT will discuss the plan and describe the nature and purpose of tracking with the resident and/or surrogate decision maker. The physician then obtains informed consent from the resident and/or the surrogate decision maker.

The physician will write in the resident's chart an order for both application of the locator tag and the category of AeroScout authorization (i.e. unauthorized, indoor only).

- ~~e. full authorization access).~~

## 2. Placement of the Resident Locator Tag:

- ~~a. If a The~~ resident's care plan ~~will shall~~ include location tracking, the ~~licensed Charge Nurse or designee will shall~~:

- ~~i. Use~~ the system database to assign a tag; place the tag on the resident (usually with a wristband; other options might include attaching to a wheel chair); and set the resident's tag to the appropriate risk category ("Unauthorized" or "Indoor Only").

- ~~ii. Check that the database correctly associates the tag to the resident's full name, Medical Record Number (MRN), date of birth, gender, primary language, and photograph.~~

- ~~iii. Test that the locator tag appears on the monitoring map.~~

- ~~a. Lastly, the licensed Charge Nurse or designee will test that the locator tag appears on the monitoring map.~~

## 3. Resident Locator System and Communication of Alerts:

- a. Location Monitoring: From a nursing station computer the neighborhood staff can locate the resident's tag on maps of the neighborhood and Laguna Honda buildings.
- b. When an alert is triggered, designated AeroScout computers at the nursing station will display a pop-up message with the resident's name, photograph, and current location on a facility map.
- c. North and South Residence Neighborhood Alerts:
  - i. Stage 1 Alert (Redirection) is triggered if an "Unauthorized" resident approaches the exit doors above the neighborhood's first main exit door. The

alert is a pre-recorded message asking the resident to step away from the exit and return to the main part of the neighborhood. (Messages are available in several languages, or can be custom recorded for the resident.

- ii. Stage 2 Alert is triggered if an "Unauthorized" resident does not respond but continues to the next door adjacent to the elevators. The resident's name, location and need for intervention is sent to neighborhood staff pagers or staff phones (SpectraLink®). Additionally, a pop-up message with the resident's name, photograph, and current location will appear on the neighborhood's designated AeroScout computers at the nursing station.

iii. Stage 3 Alert is triggered for the following:

- If an "Unauthorized" or "Indoor Only" resident exits via a delayed egress fire door. The resident's name, location and need for intervention is sent to neighborhood staff pagers or staff phones (SpectraLink®).
- If an "Unauthorized" resident approaches or enters an elevator. The resident's name, location and need for intervention is sent to neighborhood ~~staff pagers or~~ staff phones ~~s~~ (SpectraLink®), ~~and staff pagers~~, and the resident's tag status is automatically set to "Wandering". Additionally, a pop-up message with the resident's name, photograph, and current location will appear on the neighborhood's designated AeroScout computers.

~~iii.~~iv. Stage 4 Alert is triggered if a resident with an "Unauthorized" or "Indoor Only" tag exits the Pavilion main doors, exits the loading dock door, exits a ground floor exterior fire exit door, or enters the pool area. The resident's name, last known location and need for intervention is sent to neighborhood staff pagers or staff phones (SpectraLink®) and security. A pop-up notification will also appear on the neighborhood's designated AeroScout computers. The resident's tag status is automatically set to "Wandering Outdoors".

d. Pavilion Rehabilitation and Acute Neighborhood Alerts:

i. For architectural reasons, these neighborhoods only use Stage 3 and Stage 4 elopement alerts. Therefore staff in these neighborhoods will be trained to monitor the elevator area for approach by elopement risk residents.

- Customized Alert: Customized Alert only occurs on the neighborhood's Instant Notifier. Customized Alert is triggered only for individualized event.
- f. ~~Aerescout~~Aerescout Downtime: Please refer to Nursing System Manual. When there is Aerescout Downtime the Charge Nurse or designee will turn on and carry Charge Nurse pager (all downtime status updates will be

sent to the Charge Nurse pager. If the Charge Nurses' pager is malfunctioning notify the person in charge of downtime ASAP).

— Refer to Nursing System Manual #20 for other responsibilities of the charge nurse or designee during an AeroScout downtime.

— The following equipment WILL NOT function during the AeroScout downtime:

**Instant Notifier: message received from**

— Stage 2, 3, 4 and Duress alert (AeroScout)

**Spectralink Phone: messages received from**

— Stage 2, 3, 4 and Duress alert (AeroScout)

— Unauthorized Delay Egress door exit with resident name

**Staff Pager: messages received from**

— Stage 2, 3, 4 and duress alert AeroScout

— Unauthorized Delay Egress door exit with resident name

**Nurse Manager Pager: messages received from**

— Stage 3, 4 (AeroScout)

— Unauthorized Delay Egress door exit with resident name

**NM Op Pager: messages received from**

— Stage 4 (AeroScout)

**Sheriff Pager: message received from**

— Stage 4 (AeroScout)

— Unauthorized Delay Egress door exit with resident name

**Informacast**

— Stage 1 "Stop! Go back"

**4. Authorized Exits:**

a. For All Neighborhoods:

- i. Appointments and Activities within Laguna Honda: The neighborhood staff can temporarily change a resident's tag status from "Unauthorized" to "Indoor Authorization" via MobileView software, or by briefly holding a deactivating exciter (kept at the nursing station one medication room) next to the resident's locator tag. The resident can then be escorted off the neighborhood without triggering an alert. The resident's tag automatically resets to "Unauthorized" on re-entry to the unit.
- ii. Appointments and Activities outside of Laguna Honda: If a resident needs to be escorted off campus (e.g. SFGH appointment) without triggering an alert,

neighborhood staff can change a resident's tag status via MobileView software to "Full Authorization". For the North and South Neighborhoods only, the resident's tag automatically resets to the original category ("Unauthorized" or "Indoor Only") on re-entry to the neighborhood. As a confirmation of the category reset, the neighborhood staff in the North and South neighborhoods will also verify through MobileView that ~~that~~ the resident's tag has reset back to the original category. For Pavilion Residence Neighborhoods, the neighborhood staff must manually reset the resident's tag to the original category using MobileView.

- b. Pavilion Residence Neighborhoods Only:
  - i. Pavilion staff with an assigned staff locator tag can escort a tag-wearing Pavilion resident off the unit without triggering an alert if the resident and staff pass through the detector area within 5 seconds of each other.
  - ii. Pavilion neighborhood staff will watch that wander-risk residents do not accidentally or deliberately follow a staff member out a door and fail to trigger an alert.

## 5. Responding to Resident Locator System Alerts:

- a. Neighborhood staff is responsible for responding to resident locator system alerts by locating and redirecting the resident safely back to the neighborhood.
- b. If the resident elopes from the neighborhood, staff will identify the resident's location on the designated AeroScout computers and contact the Sheriff's Department for assistance.
- c. Designated staff will be deployed to the eloped resident's last detected location. These staff will carry pagers and/or staff phones (SpectraLink®) to receive updates of the resident's location.
- d. If the resident cannot be located, staff will initiate post-elopement response procedures. (See Elopement Response Procedure.)

## 6. Checking Resident Locator Tag and Function:

- a. The neighborhood Charge Nurse or Manager/designee is responsible for maintaining the database of neighborhood residents who wear locator tags, and for communicating to neighborhood staff which residents wear the tags.
- b. The neighborhood Charge Nurse or /designee is responsible for the following:
  - i. Upon admission, readmission, or relocation of a resident assigned an AeroScout tag, the Charge nurse/designee will assign and/or check that the

resident has the appropriate category of authorization on the MobileView as per physician order.

- ii. The Charge Nurse or /designee will verify that when a resident assigned a tag returns to his/her neighborhood (e.g. from OOP, outside appointments, ER visits, LHH clinic or rehab appointments), the resident is wearing the assigned tag. The Charge Nurse/ designee will also confirm through MobileView that the resident's name, MRN number, category, and status are accurate and have reverted back to the original form.

iii. Every shift, the Charge Nurse/designee will:

- Monitor that each nursing assistant documents on the DNCR that each resident assigned a tag is wearing the AeroScout tag.
- Print an AeroScout assets list report and check that each resident assigned a tag has an associated tag ID, has the correct MRN number associated with the resident, has the correct Category and Status, and resident is detected in the neighborhood, or ~~that~~ the resident's location is otherwise known (e.g., out on pass). and last update time is current.

iii.iv. Upon discharge of a resident with an AeroScout tag to home or community, the Charge Nurse or /designee will remove the AeroScout tag from the resident.

- c. The neighborhood Charge Nurse or /designee is responsible for checking at each shift the tag's battery status using the AeroScout battery level report.
  - i. If battery level is "LOW", the Charge Nurse or /designee immediately issues a new tag to the resident and places the low-battery tag in a bin to return for battery replacement.
  - ii. If the battery level is "MEDIUM", the neighborhood Charge Nurse or /designee may replace the tag or continue to watch for a few days.
- d. The assigned care-giver checks the resident's tag and strap for wear and tear at each shift.

## 7. Staff Education:

- a. Neighborhood staff shall be trained upon orientation or if transferred within Laguna Honda on the use of the resident locator system and response to its alerts.
- b. Additional education shall be provided to staff if a significant system enhancement is implemented or whenever indicated.

c. Neighborhood staff will be trained that residents with elopement/wander risk must be escorted by staff at all times while in the garden areas (detectors do not currently cover the garden areas).

~~d. Neighborhood staff will be trained that residents with elopement/wander risk must be escorted by staff at all times while in the smoking area (detectors do not currently cover the smoking area).~~

~~e.d.~~ All staff are to be educated to be cautious when entering or exiting controlled areas to prevent accidental resident elopement.

#### 8. Performance Improvement:

a. The Licensed Nurse shall complete an Unusual Occurrence report if a resident elopes from the neighborhood.

b. Resident elopement incidents will be periodically reviewed to identify process improvement opportunities and staff training needs.

#### 9. Other Uses:

a. If the Resident Care Team (RCT) identifies possible uses for the locator system that would enhance the resident's safety and quality of life, these possibilities may be discussed with the resident and/or surrogate decision-maker for approval. The use of the resident locator system shall be described in the resident's care plan.

#### **ATTACHMENTS/APPENDICES:**

None.

#### **REFERENCE:**

Aeroscout® Operation Manual

[Nursing System Manual \(LagunaNet: Nursing\)](#)

#### **CROSS REFERENCE:**

LHHPP 24-01 Elopement Response Procedure

LHHPP 24-04 Resident Found Off Grounds

LHHPP 60-04 Unusual Occurrences

Revised: 11/07/26; 12/03/27, [16/07/12](#) (Year/Month/Day)

Original adoption: 10/12/03



## CODE GREEN PROTOCOL

### POLICY:

Code Green shall be activated when a resident is determined missing from the Laguna Honda Hospital ([LHH](#)).

### PURPOSE:

To establish guidelines for ~~Laguna Honda~~[LHH](#) staff to provide an organized and prompt search for a resident who is determined to be missing.

### PROCEDURE:

#### 1. Prior To Activation Of Code Green

- a. Neighborhood of the missing resident shall conduct a search within the neighborhood as follows:
  - i. Charge nurse or designee ~~will~~shall print picture of missing resident from LCR.
  - ii. Notify [San Francisco Sheriff Department \(SFSD\)](#).
  - iii. Charge Nurse or designee ~~will~~shall call for a huddle with neighborhood staff to show the picture of the missing resident and assign staff for designated search areas.
    - Resident rooms and bathrooms in each household
    - Living rooms in each household
    - Stairwells in each household
    - 2 Medication Rooms
    - Galley and Dining Rooms
    - Offices (MDS, Nurse Manager, HIS, Conference Room, Staff Lounge, Staff Bathroom)
    - Spa Rooms, Linen Rooms, Storage Rooms, Biohazard Rooms, Linen Room, EVS Room, Laundry Room and MD Office
    - Garden and Patio (if any)

- Barber Shop and Beauty Salon
- Library
- Vending/ATM Room
- Cafeteria
- Art Studio
- John Kannaley Center and Boyd Seymour Terrace
- Chapel and Simon Auditorium
- Rehabilitation Area (OFF HOURS)
- Wellness Center (OFF HOURS)
- Clinic (OFF HOURS)

## 2. Activation Of Code Green

- a. The Charge nurse or designee of the nNeighborhood where the missing resident resides: ~~The Charge nurse or designee~~ shall dial:
  - i. 4-2999 to activate CODE GREEN once resident is confirmed missing.
  - ii. 4-2319 to inform ~~San Francisco Sheriff Department (SFSD)~~ of the CODE GREEN, neighborhood, Name of rResident and description.
- b. Nursing office staff receiving the 4-2999 will carry out the following Code Green responses:
  - i. Obtain the following information from the caller:
    - Location of neighborhood where the missing resident resides.
    - Full nName of the missing resident.
    - Full name of staff activating Code Green.
  - ii. Repeat back the information to the person activating Code Green for accuracy.
  - iii. Overhead Page:

- Initial Page – CODE GREEN (specify neighborhood) X3.
  - Ongoing Page – continue to overhead page every 30 minutes until all neighborhoods call back indicating that a search for the missing resident has been completed.
- iv. Send Text Page – 415 327 8124.
- Initially – CODE GREEN, specify neighborhood followed by first name and last name of missing resident.
  - Ongoing – Will continue to text page every 30 minutes until all neighborhoods call back indicating that search has been completed.
  - End of day – will send group page CODE GREEN remains active at 9PM if resident continues to be missing.
3. **CODE GREEN IN PROGRESS** – Once code green is activated the following will be conducted:
- a. Other Neighborhoods – Charge Nurse will receive a CODE GREEN text page with neighborhood and full name of missing resident. Search within the neighborhood will be initiated as follows:
- i. Charge nurse or designee will print picture of missing resident from LCR.
  - ii. Charge Nurse or Designee will call for a huddle with neighborhood staff to show the picture of missing resident and assign staff for designated search areas.
    - All 4 households' resident rooms and bathrooms.
    - All 4 household living rooms.
    - All 4 stairwells.
    - 2 Medication Rooms.
    - Galley and Dining Rooms.
    - Offices (MDS, Nurse Manager, HIS, Conference Room, Staff Lounge, Staff Bathroom).
    - Spa Rooms, Linen Rooms, Storage Rooms, Biohazard Rooms, Linen Room, EVS Room, Laundry Room and MD Office.

- Garden and Patio (if any).
  - iii. Charge Nurse or designee will call Nursing Office 4-1503 to report that search is completed and resident is found or not found.
  - iv. If found, Charge nurse or designee will also call the neighborhood of the missing resident to inform that resident is found, and arrange pick up.
  - v. Charge Nurse or designee on all neighborhoods on all 3 shifts will include during their change of shift report the status of CODE GREEN, a picture of the missing resident to the incoming shift until CODE GREEN is clear.
- b. ~~San Francisco Sheriff Department (SFSD)~~ – Officer on duty will receive a call from charge nurse of missing resident to inform them of the CODE GREEN, name of resident missing and description.
- i. Search will be conducted as follows:
    - Forest Hill Station;
    - LHH Grounds; and
    - LHH Old Building.
  - ii. Officer on duty or designee will call Nursing Office 4-1503 to report that search is completed and resident is found or not found.
  - iii. Officer on Duty or designee will include in their change of shift report the status of CODE GREEN, a picture of the missing resident to incoming shift until CODE GREEN is clear.
- c. Other Departments – Upon hearing overhead page, Department Manager or designee will huddle with their staff to search their respective work areas for any resident and contact the Nursing Office if a resident is found.

#### 4. Termination Of Code Green

- a. Neighborhood or Department staff will call Nursing office once the missing resident is found
- b. Nursing Office will Overhead Page CODE GREEN ALL CLEAR X3
- c. Nursing Office will send Group Page to 415 327 8124 indicating CODE GREEN ALL CLEAR
- d. Neighborhoods and Departments will shred the Missing Resident Picture once

CODE GREEN is terminated.

- e. Nurse Manager or ~~d~~Designee where missing resident resides will call SFSD at 4-2319 to indicate that resident is found.

## 5. Notification And Documentation

- a. Neighborhood where missing resident resides.
  - i. Charge Nurse or Nurse Manager will notify the following once CODE GREEN is **activated and terminated**:
    - Nursing Office
    - Nurse Manager or Nursing Ops
    - Unit Physician or on-duty physician
    - ~~San Francisco Sheriff Department (SFSD)~~
    - Chief Nursing Officer
    - Risk Management Staff
    - Appropriate Resident Care Team Members – to assist in locating/calling resident/family
    - Family or responsible party
  - ii. Will document events and notifications made in:
    - Integrated Progress Notes.
    - Unusual Occurrence Report (even if resident is found).
  - iii. Other documents to be completed – during the shift when resident is determined missing
    - “Emergency Notification of Missing Resident” form – description of resident and picture FAX to Nursing OFFICE at 415-682-1510 after search in neighborhood completed.
    - Post Elopement Form MR 170.
    - Care Plan – Initiate elopement Care Plan or Update if there’s an existing Care Plan.

- **MISSING RESIDENT INCIDENT NEIGHBORHOOD CHECKLIST** and fax to Nursing Office at 415 6821510 once search in neighborhood completed.
- b. Other Neighborhoods and Departments:
- i. Notify Nursing Office that search is completed and whether resident is found or not found
  - ii. Complete the **MISSING RESIDENT INCIDENT NEIGHBORHOOD CHECKLIST** and Fax to Nursing Office at 415 6821510 once search is completed within their assigned area.
- c. ~~San Francisco Sheriff Department (SFSD)~~ Officers:
- i. Notifies Nursing Office that search is completed and whether resident is found or not found
  - ii. Completes the **SFSD SEARCH CHECKLIST** and Fax to Nursing Office at 415 6821510 once search is completed within their assigned area.
  - iii. Completes the ~~San Francisco Police Department~~SFSD Missing Person report form
- d. Nursing Office staff
- i. Completes **MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST** and **NURSING OFFICE MISSING RESIDENT REPORT CALL LOG**
  - ii. Send completed forms to Quality Management via QM Mailbox in Nursing Office:
    - **MISSING RESIDENT INCIDENT NEIGHBORHOOD CHECKLIST** from all 13 or 14 neighborhoods
    - **MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST**
    - **NURSING OFFICE MISSING RESIDENT REPORT CALL LOG**
- e. Nursing Operations or Nurse Manager:
- i. Faxes “Emergency Notification of Missing Resident” form completed by charge nurse to the following:
    - Local emergency rooms.

- SFSD at ~~Laguna Honda~~ LHH.
  - Other agencies listed on Table 1 as appropriate.
- ii. Conducts debriefing with neighborhood staff, SFSD Staff and other appropriate staff to identify what went well and what areas needed improvement.

## 6. Downtime Procedure

- a. Text paging system – if the Cook paging system is down, nursing office staffer will Fax Code Green Alert Sheet to all neighborhood's indicating resident's neighborhood and full name.
- b. LCR System – if neighborhoods cannot print resident photo from LCR:
  - i. Neighborhood of missing resident will fax the photo from Medication Preference sheet in the Medication Book
  - ii. Nursing Office Staffer will fax the received photo to all neighborhoods
  - iii. SFSD will obtain a copy of the photo from Nursing Office

### ATTACHMENT:

None.

### REFERENCE:

LHHPP 24-01 Missing Resident Procedure  
SFSD Checklist

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 14/11/25

## **PERFORMANCE IMPROVEMENT QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM**

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (~~LHH~~~~Laguna Honda~~) ~~will~~ shall support and maintain a ~~Hospital-Wide~~Hospital-wide Quality Assurance Performance Improvement (QAPI) program.

### **PURPOSE:**

1. To ensure that patients and residents receive a consistent level of high quality care and that barriers to high quality care are identified and eliminated.

2. To facilitate continuous coordinated review of the care provided by LHH staff.

### **SCOPE:**

The scope of the QAPI plan is reflective of the care and services provided by the Hospital and addresses resident quality of care, quality of life, resident choice, care transitions and the safety of residents and health care workers.

### **PROCEDURE:**

#### **1. Characteristics of the ~~performance improvement~~QAPI process include:**

- a. All services and operations performed at ~~the Hospital~~LHH shall be considered part of the overall ~~Hospital-Wide Performance Improvement~~Hospital-wide QAPI Program, in recognition of the role of every department and every employee at ~~Laguna Honda~~LHH in providing quality care as well as the interdependence of many professions and disciplines in the delivery of quality care.

The Hospital Performance Improvement and Patient Safety (PIPS) and the Quality Council (QC) Committees ~~will~~ shall work to implement these objectives through the maintenance of an ongoing system to coordinate and evaluate quality and appropriateness of care, systems and services and to identify and address opportunities for improvement.

#### **2. Objectives of the ~~performance improvement~~QAPI process include:**

- a. Assigning responsibility for all components of the Hospital-wide QAPI~~Hospital Wide Performance Improvement~~ and /Risk Management Program.
- b. Delineating the scope of care and services provided at ~~Laguna Honda~~LHH.
- c. Identifying important aspects of care and services provided at ~~Laguna~~



~~Honda~~LHH.

- d. Identifying measurable standards (indicators) for evaluation related to important aspects of care and services.
- e. Collecting and organizing performance information from departmental and Hospital-wide ~~Hospital Wide~~ data sources.
- f. Measuring performance against established standards and evaluating results.
- g. Assessing possible causes, performance and/or systems variation that may contribute to less than optimal performance.
- h. Taking corrective actions to improve care and services.
- i. On-going monitoring to assure the effectiveness of actions taken.
- j. Documenting and reporting any discrepancies between standards and performance, identifying process barriers and opportunities for improvement, as well as progress and achievements.

### 3. Guiding Principles:

- a. The Health Commission, as the Governing Body, is engaged and supportive of the LHH's QAPI program.
- b. LHH uses QAPI data to make decisions, guide day to day operation, and prioritize performance improvement projects that includes input and experience from health care workers, residents, families and other stakeholders.
- c. The outcome of the QAPI program is reflective of the quality of care and quality of life of the residents receiving care at LHH.
- d. QAPI involves all employees and departments and includes all services provided at LHH.
- e. The QAPI program focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- f. LHH sets goals for performance and measures progress toward those goals.
- g. There is a systematic way to effectively collect, analyze, and display LHH and benchmark data to identify opportunities for improvement.
- h. LHH promotes performance improvement by encouraging staff to support one

another as well as be accountable for their own professional performance and practice.

- i. LHH supports a culture that encourages, rather than penalize employees who identify errors or system breakdowns.
- j. LHH utilizes standardized templates to document QAPI projects including highlights, progress and lessons learned and files them electronically for future reference.

#### 4. Structure and Organization:

- a. ~~Laguna Honda Hospital and Rehabilitation Center (Laguna Honda)~~LHH operates as a component of the ~~Community San Francisco~~ Health Network, Department of Public Health under the jurisdiction of the City and County of San Francisco.
- b. The Executive Administrator is accountable to the Director of Public Health for an effective, comprehensive quality improvement system at ~~Laguna Honda~~LHH.
- c. The Director of Public Health is the Chief Executive Officer of the Health Commission and is responsible for managing the operations of the Department with Health Commission approval.
- d. The Health Commission as the Governing Body is ultimately accountable for the quality of patient care.
- e. The Joint Conference Committee (JCC) monitors the effectiveness of the Hospital-wide QAPI ~~Hospital~~ Wide Performance Improvement Program on behalf of the Health Commission.
- f. The Medical Staff is delegated the responsibility to establish and maintain a PIPS ~~Hospital Wide Performance Improvement~~ Program as required by regulatory agencies and the Hospital's Medical Staff Bylaws. ~~All meetings of medical staff committees that involve discussions of the quality of medical care are part of the overall Performance Improvement Program. Minutes of these meetings are not discoverable as the purpose of these meetings is to conduct peer review in order to evaluate and enhance the quality of patient care.~~
- g. The ~~Medical Director~~Chief Medical Officer (CMO) is responsible to assure that Medical Staff quality improvement activities are clearly delineated and implemented in accordance with the outline provided in the OBJECTIVES of this performance improvement process. The ~~Medical Director~~CMO acts as Chair of the ~~Hospital-wide~~ Wide Performance ImprovementPIPS Committee, and reports to the Medical Executive Committee, the Health Commission and the Director of Public Health through the ~~Joint Conference Committee~~JCC.

- h. The ~~Director of Nursing~~Chief Nursing Officer (CNO) is responsible to assure that Nursing quality improvement activities are clearly delineated and implemented in accordance with the OBJECTIVES outlined in the performance improvement process.
- i. Each Department Manager has line responsibility to the appropriate Division Head for quality improvement activities that are clearly delineated and implemented in accordance with the OBJECTIVES outlined in this performance improvement process.
- j. Each Department Manager is responsible to assure the review and discussion of findings from data collection and analysis at regular department meetings. Significant findings from these activities ~~will~~shall be used to correct and revise systems, policies or procedures, educate and evaluate staff and resolve identified problems, and ~~will~~shall be reported to the ~~Hospital Wide Performance Improvement~~PIPS Committee on a ~~quarterly~~regular basis.
- k. The ~~Hospital-wide Quality Improvement~~PIPS Committee is a standing Medical Staff Committee, chaired by the ~~Medical Director~~CMO, and is delegated the responsibility to oversee the continuing quality improvement activities at ~~Laguna Honda~~LHH. The purpose, composition, functions and meetings of the ~~Hospital-wide Performance Improvement~~PIPS Committee are delineated in the ~~Laguna Honda~~LHH Medical Staff Bylaws.
- l. ~~The Performance Improvement Steering Committee, which consists of~~The QC is an administrative committee comprises members of the Executive Committee and ad hoc department representatives from Quality Management, Medicine, Nursing, Operations and Clinical Support, provides oversight of hospital wide performance improvement activities. The CEO and the CMO shall serve as co-chairs of QC. Members of the Performance Improvement Steering CommitteeQC, with input from ~~Hospital Wide Performance Improvement~~PIPS Committee members, ~~will~~shall provide strategic direction and vision to the designated chairs and members of the ~~P~~performance ~~i~~improvement ~~T~~teams/committees. ~~The Performance Improvement Steering Committee will meet as often as necessary to address performance improvement and related operational issues.~~
- m. The ~~Performance Improvement~~QAPI activities at the ~~Hospital~~LHH ~~will~~shall be supported and assisted by the Director of Quality Management, who ~~will~~shall:
  - i. coordinate projects of the ~~Hospital-wide Performance Improvement~~PIPS and QC Committees;
  - ii. administer the Unusual Occurrence reporting system;
  - iii. initiate and monitor problem and risk identification, investigation, corrective

action, and follow up; and

- iv. analyze data for trends and recommend or refer for action to reduce or prevent incidents that may adversely affect patient care or the safety of patients, visitors, employees and volunteers.
- n. Unusual Occurrence (UO) Report forms are completed, referred, investigated and followed up in accordance with the Hospital-~~wide~~ Wide "Unusual Occurrences" ~~p~~Policy and ~~p~~Procedures. On a regular basis the ~~Performance Improvement~~ Quality Management Manager or designee ~~will~~ shall submit statistical reports, analyses of trends and investigative studies of data gathered through the ~~Unusual Occurrence~~ UO reporting system to the ~~Hospital Wide~~ Performance Improvement PIPS Committee.

## 5. Scope of Service Provided:

- a. ~~Laguna Honda~~ LHH provides acute medical, acute rehabilitation, ~~long term rehabilitation~~, skilled nursing and palliative care outpatient specialty services for the patients/residents of San Francisco City and County. At least 90% of the patient/resident population is being provided skilled nursing, long-term care for multi-system diseases. A full range of diagnostic and treatment services are available to ~~Laguna Honda~~ LHH patients, either at this facility or via transfer arrangements with nearby acute care facilities. Frequent diagnoses, treatment regimens, and procedures are identified by Medical, Nursing and Hospital staffs for each care unit and department, and quality improvement activities are formulated accordingly.

## 6. Components of a ~~Hospital Wide Performance Improvement~~ QAPI Program: (refer to attachment – LHH QAPI Program):

- a. The formal components of the Hospital-~~wide~~ Wide ~~Performance Improvement~~ QAPI Program include performance improvement programs for acute care, acute rehabilitation, and skilled nursing services.
  - i. ~~Laguna Honda~~ LHH Acute Care ~~Performance Improvement~~ PIPS Program:
    - Focus on high-risk, high-volume, or problem-prone areas.
    - Consider the incidence, prevalence, and severity of problems in those areas, ~~and that.~~
    - Affect the health outcomes, patient safety and quality of care.
  - ii. ~~Laguna Honda~~ LHH Skilled Nursing Facility ~~Performance Improvement~~ PIPS Program:

- Focus on the resident's safety, quality of care, quality of life, and functional Independence.
- Focus on the organization's leadership abilities to provide high quality and culturally competent clinical and non-clinical services, an effective risk management and environmental safety program, as well as evidenced based staff education and training.
- Consider the incidence, prevalence, scope and severity of issues in the above areas when collaborating with an interdisciplinary team of clinical and non-clinical staff to implement a continuous performance improvement program.

iii. LHH Quality Council

- Identifies, prioritizes, implements, and evaluates opportunities to improve organizational functions and systems. Designates performance improvement tasks to facilitate interdisciplinary collaborative approaches to improving the quality of resident care and safety.
- Annually reviews and approves hospital-wide performance measures, including the evaluation of performance of resident care services provided through contractual agreement.
- Develops recommendations for performance improvement activities according to potential impact upon patient outcomes and safety and in accordance with LHH's mission, vision, care and services provided, and the population served.

- b. All departments, units, systems and processes are managed for quality of services ~~and they include services from the following departments~~as illustrated in the organizational chart (LHHPP 01-03 Hospital Organizational Chart).÷

- i. ~~Activity Therapy~~
- ii. ~~Administration~~
- iii. ~~Admitting and Eligibility~~
- iv. ~~Adult Day Health~~
- v. ~~Communications~~
- vi. ~~Education and Training~~
- vii. ~~Environmental Services~~
- viii. ~~Facility Services~~
- ix. ~~Finance~~
- x. ~~Health Information~~
- xi. ~~Human Resources~~
- xii. ~~Information Systems~~
- xiii. ~~Laboratory~~

- ~~xiv. Materials Management~~
- ~~xv. Medicine~~
- ~~xvi. Nursing~~
- ~~xvii. Nutrition~~
- ~~xviii. Operations and Clinical Support~~
- ~~xix. Pharmacy~~
  - ~~• Quality Management~~
- ~~xx. Radiology~~
- ~~xxi. Rehabilitation~~
- ~~xxii. Respiratory~~
- ~~xxiii. Social Services~~
- ~~xxiv. Telecommunications~~
- ~~xxv. Utilization Management~~

## 7. Reporting:

- a. Each component of the Hospital-wide ~~Wide Performance Improvement~~QAPI Program shall submit regular reports to the ~~Hospital Performance Improvement~~PIPS Committee or QC. Documentation in the form of data collected, worksheets, problem evaluation, as examples, should be maintained on file in the department.

The quarterly or semi-annual report to PIPS or QC ~~report should shall~~ summarize activities and include the following information:

- i. Important aspect(s) of care or services reviewed
  - ii. Measurable standards (indicators) used for each aspect
  - iii. Results of the review
  - iv. Evaluation of results and opportunity for improvement
  - v. Action planned and/or taken
  - vi. Evaluation of corrective actions taken
- b. Multidisciplinary and interdisciplinary reporting concerns.
    - i. In a health care institution, systems often flow between two or more departments, and depend upon interdisciplinary communication and cooperation to function smoothly. Therefore the important aspects of care and services of any one department ~~must shall~~ include other disciplines in cooperative monitoring of at least one system or process. All departments involved should consult and collaborate on the subject(s) to be monitored prior to instituting the activity.

Reports ~~should~~ shall reflect continuity from quarter to quarter so that a clear track of problems identified and resolved ~~will~~ shall be reflected over time.

Reports regarding the results of monitoring activities, actions taken and effectiveness of action taken ~~will~~ shall be presented regularly to the ~~Hospital Wide Performance Improvement PIPS~~ PIP Committee or QC, Medical Executive Committee, Nursing Quality Improvement Council and to the ~~Joint Conference Committee~~ JCC.

## 8. Evaluation:

- a. Evaluation of the effectiveness of the ~~Laguna Honda~~ LHH ~~Performance Improvement~~ QAPI Program, its ongoing monitoring activities, related interventions, and the on-going performance improvement plan ~~will~~ shall be done by the ~~Hospital Wide Performance Improvement PIPS~~ PIP Committee or QC and reviewed by the ~~Joint Conference Committee~~ JCC on an annual basis.

### ATTACHMENT:

LHH QAPI Program

### **REFERENCES:**

LHHPP 01-03 Hospital Organizational Chart

Performance Improvement Organizational Chart

Performance Improvement Reporting Calendar

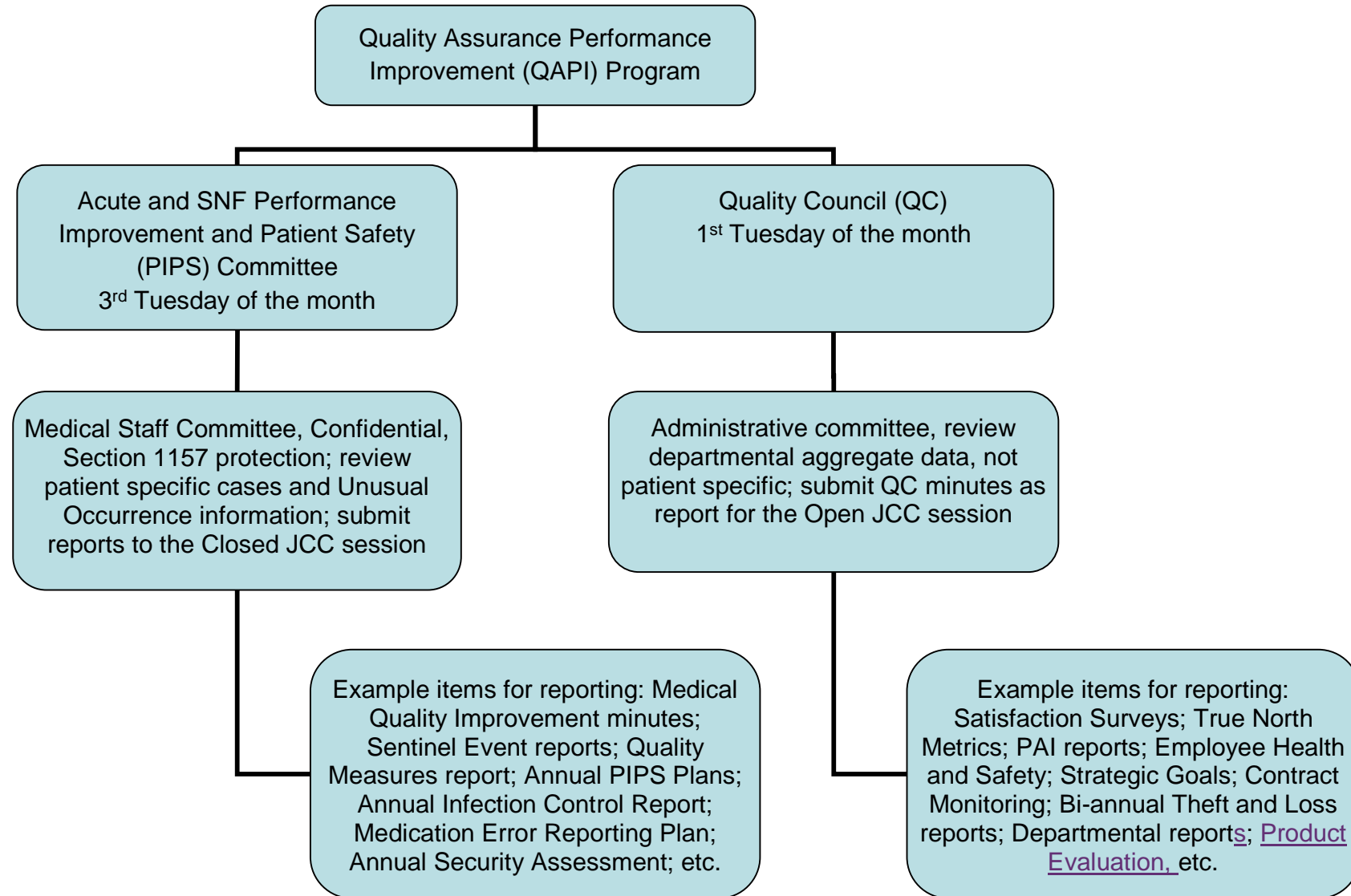
Performance Improvement Team/Committee Description

Performance Improvement Team/Committee Meeting Calendar

Revised: 98/04/01, 08/01/08, 16/07/12 (Year/Month/Day)

Original adoption: 95/05/01

Attachment: LHH QAPI Program





## REVIEW OF SENTINEL EVENTS

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) employees shall report and investigate all sentinel events.

### PURPOSE:

1. To facilitate the investigation of sentinel events, including performance of a root cause analysis, to ensure that appropriate corrective actions are taken to minimize recurrences and protect residents.
2. To have a positive impact in improving patient/resident care; treatment and services; and minimize the risk of future adverse events.
3. To focus the attention of the organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures/gaps in processes, or organizational culture).
4. To increase general knowledge about sentinel events, their contributing factors and strategies for prevention.

### DEFINITIONS:

1. Division Heads: Individuals responsible for the following divisions within the hospital include: Nursing Services, Medical Services, Clinical Services, Operations, Finance, Information Services, and Human Resources.
2. Joint Conference Committee: A subcommittee appointed by the Health Commission, which serves as the Governing Body, to oversee administration of Laguna Honda Hospital and Rehabilitation Center.
3. Medical Peer Review/Credentials Committee: A committee of the Medical Staff that comprises certain physician members of the Medical Executive Committee.
4. Performance Improvement and Patient Safety (PIPS) Committee: A committee of the Medical Staff, with interdisciplinary membership representing medicine, psychiatry, rehabilitation, nursing, administration, pharmacy, infection control, nutrition services, health information services, activity therapy, social services, Deputy City Attorney and the quality improvement coordinator.
5. Root Cause Analysis: A systematic process used to identify the causal factors that contributed to the event or problem. The root cause analysis focuses primarily on systems and processes, while understanding how individual performance contributed and is influenced by system factors. It is used to identify opportunities

for improvement in systems and/or processes with the goal of reducing the likelihood of recurrence of comparable or related events.

6. Sentinel Event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- a. Death
- b. Permanent harm
- c. Severe temporary harm\* (critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

7. Other Reviewable Events

a. An event is also considered sentinel if it is one of the following:

- i. Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, ~~including from the hospital's emergency department (ED)~~
- ~~ii. Unanticipated death of a full-term infant~~
- ~~iii. Discharge of an infant to the wrong family~~
- ~~iv.ii.~~ Abduction of any patient receiving care, treatment, and services
- ~~v.iii.~~ Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting ~~(including the ED)~~, leading to death, permanent harm, or severe temporary harm to the patient
- ~~vi.~~ Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- ~~vii.iv.~~ Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- ~~—~~ Acts of major security issues or violence such as ~~r~~Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of anyone any person while on site at the hospital.

~~ix-v.~~ v. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure

vi. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery

## **PROCEDURE:**

### **1. Sentinel Event Notification**

- a. During regular business hours, Laguna Honda employees will report sentinel events to their Division Heads. The Division Head will immediately notify the Administrator on Duty (AOD), the Executive Administrator, the Chief Nursing Officer, the Chief Medical Officer, the Director of Quality Management, the Deputy City Attorney (DCA) and the Risk Management Nurse (RMN) or designee.
- b. After regular business hours, Laguna Honda employees will report sentinel events to their Division Heads, if available, or if not available, to the AOD. If the employee notifies the Division Head, the Division Head will notify the AOD who will immediately notify the individuals listed above. If the AOD is notified directly by the employee, the AOD will notify the individuals listed above, as well as the division head.

The Chief Medical Officer or designee will determine whether the event will be treated as sentinel based on the information provided by the preliminary investigation.

- c. The RMN or designee will evaluate the incident and, if applicable, timely report the event to the California Department of Public Health (CDPH) as per regulation.

### **2. Sentinel Event Process**

- a. The Division Head(s) or designee(s) will complete the initial sentinel event investigation in consultation with the Deputy City Attorney. The RMN or designee, under the auspices of the PIPS Committee, will appoint an investigation team to gather facts and to perform a root cause analysis. The investigation team will include the Deputy City Attorney and the Director of Quality Management in addition to appropriate clinical and administrative staff, as necessary. The initial meeting will convene no later than three (3) business days after the sentinel event. The team will investigate the sentinel event to identify the facts, systems issues and processes that affect the care, services or safety of residents, visitors or staff, to decide preventability and to propose corrective action. Within 10 days of the initial meeting, the RMN or designee will

provide documentation of the investigation and plan of correction to the Executive Administrator, through the Chair of the PIPS Committee.

- b. The investigation team, in consultation with the RMN or designee, shall develop the plan of correction, identify individual(s) responsible for corrective action, and will submit its findings and recommendations to the PIPS Committee. The RMN or designee will distribute the plan to the division or department head of the person assigned to carry out the activities and processes toward resolution. The RMN or designee may inform or consult with other Laguna Honda administrative, executive or medical committees. The RMN or designee will monitor the implementation of the plan of correction at least weekly until completed and will report findings to PIPS Committee until resolved. The investigation team may meet more frequently, as necessary, to assure that the plan of correction is implemented and resolves the issues. If the PIPS Committee determines of the plan of correction does not obtain the desired outcomes within specified time frames, the RMN or designee will report the matter to the Executive Administrator.
- c. The RMN or designee will report to the Director of Quality Management any changes in the status of the affected party. Throughout this process and within the appropriate time frame, the Director of Quality Management will ensure that Laguna Honda reports the event to external and/or regulatory agencies.

### **3. Reporting**

- a. The RMN or designee will present the results of all investigations, interviews and plans of correction to the Chair of the PIPS Committee. The Chair of the PIPS Committee or designee will report findings to the Medical and Hospital Executive Committees and the Joint Conference Committee. These reports will identify systems problems and opportunities for improvement. If the findings identify an individual responsible for the sentinel event, the PIPS Committee will refer these findings to the appropriate department or to the Medical Peer Review / Credentials Committee for further investigation and appropriate corrective action.

### **4. Record Maintenance**

- a. The RMN or designee will maintain a confidential file for all documented discussions, meetings and investigations regarding the event in a central repository along with the approved Plan of Correction and outcome data.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP File: 60-03 Incidents Reportable to the State of California  
Joint Commission Standards on Sentinel Events (CAMLTC Update 1, March 2012)

Revised: 00/03/15; 02/03/14, 07/12/17, 08/01/08, 15/01/13, 16/03/08, 16/07/12  
(Year/Month/Day)

Original adoption: 97/11/10

# MEDICAL SURGE EMERGENCY QUICK REFERENCE RESPONSE GUIDE

## ANTICIPATED IMPACT

### Moderate to Significant

1. Disruption of normal operations and services.
2. Reduced capability of local hospital emergency departments to manage surge leading to a need for Laguna Honda to assist by admitting stable patients from other hospitals.
3. Influx of community residents who may be seeking basic first aid or guidance in the event of a large scale incident.

## MISSION

To participate in the city-wide response to any incident that exceeds the capabilities of the normal medical infrastructure in San Francisco. This encompasses the ability to assist in caring for stable patients from Zuckerberg San Francisco General (ZSFG) or other area hospitals to allow emergency departments to manage a surge of victims of trauma or acute illness as well as providing basic first aid to area residents in the event of a large-scale event leading to widespread casualties.

## GOAL

## ACTION

Activate the Hospital Incident Command System (HICS)

As soon as any Laguna Honda supervisor is aware of medical surge conditions, the supervisor will notify the Executive Administrator or Administrator on Duty (AOD). The Administrator will activate HICS according to the procedures in the Laguna Honda Emergency Response Plan.

Accommodate influx of stable patients from other hospitals

Laguna Honda anticipates being able to provide at least 50 beds, cots, or gurneys for additional patients. This includes available beds in neighborhoods, 15 cots, 2 gurneys per neighborhood, and 6 gurneys in the clinic. Surge may be expanded beyond 50 through resource requests for both additional beds and staff.

The process of transfer of patients is initiated by the Incident Commander, who will assign roles in the HICS Planning and Operations Section to manage bed control, admissions, support services such as nutrition and pharmacy. The Logistics Section will provide support to responders as well as gathering necessary equipment and supplies such as beds, cots, and other medical equipment. The Finance Section will be staffed to track expenditures. The command center will initiate appropriate staff call back procedures to accomplish the following.

1. Nursing and Medical Services will collaborate to discharge Laguna Honda's current acute residents to their usual neighborhoods and relocate rehab residents to available beds in the neighborhoods.
2. Additional beds may be set up in the Meadow and Ocean rooms as needed to accommodate additional rehab residents.
3. Admissions will begin with ZSFG patients who have been pre-approved for admission to Laguna Honda. Other stable patients will be admitted as necessary upon approval by medical staff.

Triage and treatment of community members who come seeking first aid.

Laguna Honda is the designated facility for first aid treatment for residents of the Sunset District in the event of a city-wide multiple casualty event. During any such event, the HICS command center would initiate the process of triage and treatment of community members.

1. Persons seeking first aid shall be directed to the outpatient clinic by cadets monitoring facility entrances.
2. The command center will assign an MD or RN to manage triage. Additional medical and nursing staff will be assigned to the clinic to provide first aid as needed.
3. Community members who present with injuries needing care that is beyond the capabilities of Laguna Honda will be transported to ZSFG or UCSF if possible.

## CODE SILVER – ACTIVE SHOOTER

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) 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~~LHH.

### 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~~LHH 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~~shall 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. Movement of shooter
  - iv. Number of victims and/or hostages
- b. If you call 911, the dispatchers will notify the Laguna Honda Sheriffs immediately.
- c. The ~~Laguna Honda~~ LHH 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. All other staff shall attempt to communicate the Code Silver situation.
- f. The Sheriffs will make other necessary announcements overhead or 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:**

[75-10 Security Services Operating Procedures](#)

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, 16/07/12 (Year, Month, Day)

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.

**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.

**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.**

**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.



Laguna Honda Hospital

**Code Silver  
Active Shooter  
Response Guide**

**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.

**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.

**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.

## INTRAVASCULAR DEVICE GUIDELINES

### POLICY:

1. Intravascular device policies shall be ~~These guidelines provide the basis for prevention of infections associated with intravascular device use and are~~ consistent with guidelines by the Institute of Healthcare Improvement (IHI) "~~Central Line Bundle~~" (2007) and the Centers for Disease Control and Prevention (CDC) "Guidelines for the Prevention of Intravascular Catheter-Related Infections" ~~(2002)~~.
2. Intravascular devices shall be used for the minimum amount of time necessary.

### PURPOSE:

To provide general guidelines on intravascular devices that are consistent with current national standards for prevention of catheter-associated bloodstream infection. ~~The Infection Control program at Laguna Honda Hospital (LHH) has adopted guidelines for the management of intravascular devices to prevent catheter-associated bloodstream infections that are consistent with CDC guidelines.~~

### PROCEDURE:

1. Ongoing prevention and management of catheter-associated blood stream infections is achieved through multidisciplinary activities including education, hand hygiene program and observations, antimicrobial stewardship activities, and ongoing surveillance.
2. Performance improvement efforts shall be ongoing and based upon surveillance findings combined with improvement initiatives and evidence-based recommended practices.
3. The Infection Prevention and Control Officer (IPCO) reports monthly acute unit surveillance data for Central Line Associated Blood Stream Infections (CLABSI) to the CDC National Health Safety Network (NHSN).
4. Insertion of central venous catheters (CVC's) (any line ending in a great vessel) is described in LHH Medical Policy and Procedure on Central Line Insertion (D10-02) and includes full barrier precautions and judicious use of devices.
5. Insertion and care of intravascular devices is described in nursing policies and states the appropriate discipline to perform tasks associated with peripherally inserted central catheters (PICCs), central venous catheters, tunneled devices and peripheral midline catheters and whether additional training is required.
6. Clinicians shall follow general guidelines for preventing catheter-related bloodstream infections that include education and training, demonstrated competency, hand

hygiene and aseptic technique, appropriate skin preparation, catheter site dressing regimens, resident cleansing, use of catheter securement devices, antimicrobial/antiseptics and impregnated catheters/cuffs, and anticoagulants and removal/replacement procedures.

7. Clinicians shall participate in **education and training** provided initially and annually through Bloodborne Pathogen required training and licensed nurse orientation with additional training as scheduled.

8. **Nursing competency** with intravascular devices is evaluated and monitored on orientation and in conjunction with performance appraisals.

4.9. **Hand hygiene** activities and aseptic technique specific to intravascular device management include the following CDC recommendations:

- a. Perform hand hygiene procedures, either by washing hands with soap and water or with alcohol-based hand rubs (ABHR).
- b. Hand hygiene should be performed before and after palpating catheter insertion sites as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter.
- c. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained.
- d. Maintain aseptic technique for the insertion and care of intravascular catheters.
- e. Wear clean gloves, rather than sterile gloves, for the insertion of peripheral intravascular catheters, if the access site is not touched after the application of skin antiseptics. Category IC.

10. Clinicians shall follow **skin preparations** as outlined in nursing procedures and which may include the following CDC recommendations:

f.a. 70% alcohol, tincture of iodine, or alcoholic chlorhexidine gluconate solution before peripheral venous catheter insertion.

g.b. >0.5% chlorhexidine with alcohol and catheter site dressing for central lines.

h.c. Antiseptics should be allowed to dry according to the manufacturer's recommendation prior to placing the catheter.

~~i. **Healthcare Worker Education and Training:** In order to improve compliance to the recommended guidelines it is essential that health care workers involved in the placement and care of the lines understand the rationale behind each required~~

~~component. To accomplish this goal Infection Control will consult with appropriate departments on education and training of health care workers regarding indications for the use of, and procedures for, the insertion and maintenance of intravascular devices and appropriate infection control measures to prevent device-related infection.~~

2.11. Catheter site dressing changes are usually transparent or semipermeable but may include gauze dressings until diaphoresis or site bleeding is resolved.

- a. Replace site dressing if the dressing becomes damp, loosened, or visibly soiled and as follows.”
  - i. Every 2 days for gauze dressings on short-term CVC’s.
  - ii. At least every 7 days for transparent dressings on short-term CVCs.
  - iii. No more than once per week for tunneled or implanted CVC sites until the insertion site has healed (unless dressing is soiled or loose).
  - iv. The CDC does not have recommendations regarding the necessity for any dressing on well-healed exit sites of long-term cuffed and tunneled CVCs. Current nursing policy advises weekly and PRN.
- b. Monitor the catheter site visually when changing the dressing or by palpation through an intact dressing on a regular basis, depending on the clinical situation of the resident.
- c. Tenderness at the insertions site, fever without obvious source, or other manifestations suggesting local or bloodstream infection warrants removal of the dressing to allow thorough examination and reporting suspicious findings to the physician.
- d. Encourage the resident/ family to report any changes in their catheter site or any new discomfort t is symptomatic.
- e. Do not use topical antibiotic ointment or cream on insertion sites except as ordered for dialysis catheters due to the potential for fungal infections and antimicrobial resistance.
- f. Do not submerge catheter or catheter site in water. Showering is permitted with precautions taken to reduce the likelihood of introducing organisms into the catheter.
- f.g. Usual bathing schedule and products are appropriate in the long-term care setting unless the resident is infected or colonized with carbapenem-resistant Enterobacteriaceae (CRE), in which case chlorhexidine 2% is used.

- g.h. Catheter securement devices are recommended to reduce the risk of infection, catheter migration and dislodgement.
- 3.12. CVC catheters expected to remain in place for more than five (5) days are recommended to be chlorhexidine/ silver sulfadiazine or minocycline/ rifampin impregnated if the CLABSI rate is not decreasing after efforts to reduce CLABSI rates.
13. Prophylactic antimicrobial lock solution is generally not recommended unless there is a history of multiple catheter related blood stream infections (CRBSI) despite optima maximal adherence to aseptic technique for residents with a long term catheters.
- ~~a. Care and Management of Central Lines~~
- ~~a. Review the necessity of maintaining a central line to prevent unnecessary delays in removing lines that are no longer clearly necessary. The risk of infection increases over time as the line remains in place and the risk of infection is decreased if removed.~~
- ~~— Catheter site care will be performed in accordance with Nursing policies J6.0 Intravenous (IV) Therapy, J7.0 Central Venous Access Device (CVAD) Management and J7.1 Peripherally Inserted Central Catheters (PICC).~~
- 4.14. Routine use of anticoagulants to reduce the risk of catheter-related infection is not recommended.
- 5.15. Resident / family teaching shall be provided by licensed nurses at the appropriate level of understanding and level of independence.
- a. Teach/ assist with hand hygiene and to avoid touching catheter site.
- b. Avoid submerging insertion site; showering is acceptable with adequate water proof dressings to prevent contamination of site.
- c. Teach catheter care as appropriate to resident's level of ability to maximize independence and/ or in preparation for discharge.
- d. Encourage patients to report any changes in their catheter site or any new discomfort to their provider.
- 6.16. Blood cultures shall be ordered by physicians when infection is suspected. Negative cultures suggest that the intravascular device is an unlikely source of infection.
- ~~7. Surveillance for Catheter-Related Infection~~
- ~~a. : Conduct surveillance for intravascular device-related infections to determine device-specific infection rates, to monitor trends in these rates, and to assist in identifying lapses in infection control practices within our own institution.~~



- ~~b. To facilitate comparisons with national trends, express data as incidence density rates, i.e. the number of catheter-related infections or catheter-related bloodstream infections per 1,000 catheter days.~~

~~8. Evaluation of Fever and/or Suspected Catheter-Related Infections:~~

- ~~a. The external catheter site should be inspected when the resident is febrile or catheter-related infection is suspected for other reasons. The catheter should be removed and replaced at another anatomic site if there are signs/symptoms of local insertion site infection (erythema, purulence, and/or tenderness).~~
- ~~b. Do not routinely replace non-tunneled central venous catheters or PICCs as a method to prevent catheter-related infections, as this may result in unnecessary procedures, additional expense and difficulty obtaining future intravenous access.~~
- ~~c. If the resident is hemodynamically or otherwise unstable and catheter-related infection is a possible cause, the catheter should be removed and replaced at another anatomic site.~~
- ~~d. Do not discontinue an existing intravascular catheter when bacteremia is not likely related to the catheter in question. Seeding of intravascular catheters when residents are bacteremic from other sources (e.g. pneumonia, urosepsis) is uncommon.~~
- ~~e. If the resident is stable with no evidence of local site infection, 2 peripheral blood cultures should be drawn, and the catheter may be left in place.~~
  - ~~i. If blood cultures are negative, the catheter is an unlikely source of infection. Blood cultures should be repeated as clinically indicated.~~
- a. If two or more blood cultures are positive for an organism which commonly causes catheter-associated bacteremia (e.g. *Staphylococcus aureus*, coagulase negative staphylococci, enterococci, or candida species), the catheter should generally be removed unless it is likely that the infection is from another site.
- b. In some instances, retention of the catheter can be considered for less virulent organisms, such as coagulase negative staphylococci. If only one blood culture is positive or an atypical organism is isolated, catheter removal may be considered on a case-by-case basis.

~~6. Care of Catheter Site~~

- ~~a. Hand hygiene:~~



- ~~i. Hand washing or use of an alcohol-based waterless hand cleaner will occur before and after manipulating catheter insertion sites~~
- ~~ii. Manipulation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained.~~
- ~~iii. Hand hygiene will be performed before donning and after removing gloves~~
- ~~iv. Wear gloves when changing the dressings on intravenous devices.~~
- ~~v. Use either sterile gauze or transparent dressings to cover the catheter site.~~
- ~~vi. Replace catheter site dressing when the device is removed or replaced or when the dressing becomes damp, loosened, or soiled. Change dressings more frequently in diaphoretic residents.~~
- ~~vii. Avoid touch contamination of the catheter insertion site when the dressing is replaced.~~

#### 9.17. 7. Selection and Replacement of Intravascular Devices

- a. Select a device with the lowest relative risk of complications (infectious versus non-infectious) and the lowest costs for the anticipated type and duration of intravascular therapy.
- b. Remove any intravascular device as soon as its use is no longer clinically indicated.
- c. Refer to device-specific nursing procedures for details on frequency for replacing particular types of intravascular device and whether the physician or nurse may do the procedure.
- d. Current guidelines for peripheral catheters state there is no need to replace more frequently than every 72-96 hours and nursing policy advises replacing after 96 hours or obtain a physicians order to extend the time if vascular access is compromised.
- b. Current guidelines for midline catheters recommend replacement only when there is a specific indication.

#### 18. Recommendations for replacement of administration sets includes the following:

- a. No more frequently than at 96-hour intervals but at least every 7 days if used continuously and NOT receiving blood, blood products or fat emulsions.

b. Within 24 hours of initiating infusion for tubing used to administer blood, blood products, or fat emulsions (those combined with amino acids and glucose in a 3 in 1 admixture or infused separately.)

c. Change needleless connectors/ components as least a frequently as the administration set

19. Document and promptly report signs of infection. Document other interventions according to nursing procedures.

**ATTACHMENT:**

None.

**REFERENCE:**

LHH Medical Policy D10-02 Central Line Insertion

LHH Nursing Policy J6.0 Intravenous Therapy

LHH Nursing Policy J7.0 Central Venous Access Device (CVAD) Management

LHH Nursing Policy J7.1 Peripherally Inserted Central Catheters (PICC)

CDC (201102). Guidelines for the Prevention of Intravascular Catheter-Related Infections. Retrieved February 11, 2016 @

<http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf> on July 27, 2009 from [http://www.cdc.gov/ncidod/dhqp/gl\\_intravascular.html](http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html)

Institute for Healthcare Improvement How-to Guide: Prevent Central Line-Associated Bloodstream Infections (CLABSI), updated March 2012, available at [www.ihc.org](http://www.ihc.org)

<http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx>

~~LHH Nursing policy J6.0 Intravenous Therapy~~

~~LHH Nursing policy J7.1 Peripherally Inserted Central Catheters (PICC)~~

~~LHH Nursing policy J7.0 Central Venous Access Device (CVAD) Management~~

Most recent review:xx/xx/xx (Year/Month/Day)

Revised: 16/07/12 (Year/Month/Day)

xx/xx/xx

Original adoption: Est. 05/11/01xx/xx/xx

## RESPIRATORY CARE GUIDELINES

### POLICY:

~~Residents at risk for acquiring pneumonia include elderly, and persons who have severe underlying disease, immunosuppression, depressed sensorium or cardiopulmonary disease.~~

1. Management of residents and equipment to prevent healthcare associated pneumonia and other respiratory tract infections shall be done according to the following procedure and other related policies. ~~adopted guidelines.~~
2. Staff shall follow standard and transmission based precautions, including hand hygiene and appropriate use of gloves and other personal protective equipment (PPE).
- 4.3. Respiratory infection surveillance and antimicrobial stewardship is ongoing.

### PURPOSE:

To minimize the potential for acquiring healthcare associated pneumonia and other respiratory infections in a manner that is consistent with CDC guidelines. ~~The Infection Control program at Laguna Honda Hospital (LHH) has adopted CDC guidelines to minimize the potential for health-care associated pneumonia and other respiratory tract infections.~~

### PROCEDURE:

1. Staff shall follow related LHH policies that address potential risk factors for healthcare associated respiratory infections. Risk factors generally include (CDC 2003):
  - a. factors that enhance colonization of the oropharynx and/or stomach by microorganisms; (e.g., administration of antimicrobial agents, admission to the ICU, or presence of underlying chronic lung disease);
  - b. conditions favoring aspiration into the respiratory tract or reflux from the gastrointestinal tract (e.g., initial or repeat endotracheal intubation; insertion of nasogastric tube; supine position; coma; surgical procedures involving the head, neck, thorax, or upper abdomen; and immobilization due to trauma or illness);
  - c. host factors such as extremes of age, malnutrition, and severe underlying conditions, including immunosuppression;
  - d. potential exposure to contaminated respiratory devices and/or contact with contaminated or colonized hands, mainly of health-care personnel.

- e. Risk factors also include prolonged use of mechanical ventilatory support, which is generally not applicable at LHH unless a resident is admitted post ventilator support use.
2. LHH policies that address the above risk factors include, but are not limited to, policies addressing (see references):
- a. Oral care
  - b. Prevention of complications of immobility, including turning, repositioning, ambulation and procedures to maximize independence in activities of daily living.
  - c. Use and cleaning of respiratory equipment and devices.
  - d. Pneumococcal and influenza vaccines and respiratory hygiene
  - e. Facility monitoring and maintenance to prevent and detect contaminated air and water supply equipment (i.e. with potential pathogens such as legionella and aspergillus.)
- 4.3. General guidelines for maintaining respiratory equipment and devices include (see references): ~~Maintenance of Respiratory Equipment and Devices~~(Refer to nursing and respiratory therapy policies for details.)
- a. Most respiratory equipment and devices are single use disposable items.
  - b. Do not reprocess equipment or devices that are manufactured for a single use only, unless data indicate that reprocessing such items poses no threat to the resident, is cost-effective, and does not change the structural integrity or function of the equipment or device (refer to G2 ~~Disposable Medical Supplies policy, section C3~~Classification of Reusable Medical Devices and Processing).
  - c. Replace nebulizer tubing and mask according to nursing policy, currently every 24 hours.
  - d. Handle, dispense and store all multi-dose medication vials according to manufacturer's instructions. Multi-dose medication vials are to be dated when opened.
  - e. Use sterile water for rinsing reusable semi-critical equipment and devices used on the respiratory tract after they have been disinfected chemically.
  - f. All touch surfaces of respiratory equipment should be surface cleaned/disinfected daily.

- a.g. Thoroughly clean all equipment and devices before sterilization or disinfection.
  - h. Sterilize or use high level disinfection for semi-critical equipment or devices. ~~(refer to Reusable Resident Care Equipment policy, Section G2).~~
  - b.i. Tracheostomy care and suctioning shall be performed aseptically according to nursing policy and procedures.
4. LHH facility services staff and vendors shall maintain and monitor water and air delivery systems to prevent contamination by potential pathogens, such as legionella and aspergillus. **Prevention and Control of Legionnaires Disease**
5. ~~—~~
- a. LHH does not have cooling towers, which drastically reduces the chance of a Legionnaire's disease outbreak.
  - a. A Legionella Hazard Analysis Critical Control Plan (HACCP) is available to guide water plan-related maintenance and monitoring. This plan is kept in Facility Services.
  - b. Water in boilers is heated to the recommended temperature range to inhibit microbial growth and is monitored continuously by engineers.
  - a. ~~Use sterile water for rinsing reusable semi-critical equipment and devices used on the respiratory tract after they have been disinfected chemically.~~
  - b. ~~Do not reprocess equipment or devices that are manufactured for a single use only, unless data indicate that reprocessing such items poses no threat to the resident, is cost-effective, and does not change the structural integrity or function of the equipment or device (refer to Disposable Medical Supplies policy, section C3).~~
  - c. ~~All touch surfaces of respiratory equipment should be surface cleaned/ disinfected daily.~~
1. ~~Nebulizers:~~
- a. ~~Between treatments on the same resident, volume nebulizers are replaced every 24 hours.~~
  - b. ~~Handle, dispense and store all multi-dose medication vials according to manufacturer's instructions. Multi-dose medication vials are to be dated when opened.~~
- 2. ~~Precautions to Prevent Health-care Associated Pneumonia~~**

- ~~1. Use Body Substance Precautions for all resident care.~~
- ~~2. Tracheostomy care:~~
  - ~~a. Perform tracheostomy under sterile conditions.~~
  - ~~b. Care for tracheostomy aseptically until tracheostomy wound is healed.~~
  - ~~c. Initial dressing change after trach insertion is completed by physician.~~
  - ~~d. Stoma care is performed every shift and as needed.~~
  - ~~e. When changing a tracheostomy tube, use aseptic techniques and replace the tube with one that has undergone sterilization or high level disinfection. Gloves, masks, goggles, and plastic aprons are to be worn by the nurse when the resident has copious secretions. The Shiley disposable inner cannula is for a one-time use only.~~
- ~~3. Suctioning of respiratory tract secretions:~~
  - ~~a. Each resident has to have his/her own suctioning and cleaning set which is discarded after every use. Suction connecting tubing and catheter plug is to be changed every shift as necessary.~~
  - ~~b. To suction more than one orifice, suction tracheostomy first, nose second, and mouth last. Rinse catheter tip in sterile saline between insertions. (Refer to Tracheobronchial Suctioning LHH Nursing Policies and Procedures I.30)~~
4. 5. Primary prevention of Legionnaire's Disease. —when no cases of health-care associated legionellosis have been documented, includes maintaining a high index of suspicion for legionellosis and appropriately using diagnostic tests for legionellosis in residents with health-care associated pneumonia who are at high risk of developing the disease and dying from the infection.
  - a. If one or more healthcare associated Legionella infection occurs then culturing the facility water may be indicated.
  - b. Legionella infection is reportable to the Infection Prevention and Control Officer (IPCO). IPCO will:
    - i. Contact the local and state health departments.
    - ii. Conduct a combined epidemiological and environmental investigation to determine the source under the guidance of the local or state health department and in coordination with facility services recommended

mitigation activities, such as superheating or hyperchlorination of contaminated water systems.

iii. Keep ~~adequate~~ records of all infection control measures.

#### **5. Primary prevention of Aspergillosis includes:**

a. Provide a private room for residents on neutropenic precautions.

i. Provide a well-fitting mask when resident must leave the room.

ii. Minimize the time out of room

iii. Coordinate EVS cleaning when the resident is out of the room as much as possible to decrease aerosolization of spores

b. During construction in areas with high risk residents provide barriers, and re-route traffic flow and clean newly constructed area prior to residents entering. (Refer to F1 Renovation / Construction ~~infection control construction policy~~ Infection Control Guidelines).

c. In case of an aspergillosis case among residents or staff, report to IPCO. IPCO will:

i. Begin a prospective and retrospective review for additional cases.

ii. If evidence of continuing aspergillosis infection is present, coordinate with facility services as above to eliminate the source of infection.

~~3. Clinicians shall continue to collaborate with IPCO for consultation, required reporting and to obtain case-specific recommendations from the SFDPH Communicable Disease Prevention and Control Unit as needed and as required for outbreaks or single cases of specific infections. (See C1 Alphabetical List of Diseases/ Conditions with Required Precautions.)~~

~~a. Respiratory equipment and devices shall be maintained according to these guidelines~~

~~b. Cooling towers shall be constructed and/or maintained according to manufacturer's recommendations~~

~~c. Aerosol drift should be minimized and directed away from the hospital air intake system.~~

~~d. An effective biocide should be used regularly.~~

~~e. Adequate maintenance records should be kept.~~

5. ~~Secondary prevention—when cases of health-care associated legionellosis have been documented:~~
  - a. ~~Contact local / state health department.~~
  - b. ~~Conduct a combined epidemiological and environmental investigation to determine the source.~~
  - c. ~~If the heated water system is implicated:~~
    - i. ~~Water system should be decontaminated by superheating or hyperchlorination, according to current guidelines.~~
    - ii. ~~Potable water should be maintained at the outlet at 50°C or <20°C, chlorinate heated water to achieve 1-2mg/L of free chlorine at the tap~~
    - iii. ~~Instantaneous heat exchangers are maintained at 55°C.~~
    - iv. ~~Hot water storage tanks and water heaters are cleaned to remove accumulated scale and sediment and chlorinated to achieve 1-2mg/L of free chlorine at the tap.~~
  - d. ~~If the cooling towers or evaporative condensers are implicated, the cooling tower should be decontaminated according to current guidelines.~~
    - i. ~~Assess the efficacy of implemented measures by collecting specimens for culture at 2 week intervals for 3 months.~~
    - ii. ~~If all cultures are negative, collect cultures monthly for another 3 months.~~
    - iii. ~~If Legionella sp. are detected in one or more cultures, reassess control measures, modify accordingly and repeat.~~
    - iv. ~~Keep adequate records of all infection control measures.~~
6. ~~Prevention and Control of Aspergillosis~~
  - a. ~~Specialized-care units for residents at high risk for infection shall be maintained according to current guidelines to minimize fungal spore counts, utilizing:~~
    - i. ~~HEPA filtration~~
    - ii. ~~directed airflow patterns~~
    - iii. ~~positive pressure relative to the corridor~~



- ~~iv. properly sealed room~~
  - ~~v. high rates of room air exchange~~
- ~~7. In existing facilities with no cases of health-care associated Aspergillosis:~~
- ~~a. Place residents who are at high risk for infection in a protected environment.~~
  - ~~b. Routinely inspect air-handling systems.~~
  - ~~c. Minimize the length of time that high risk residents are outside their rooms. Wearing a well-fitted mask may reduce the resident's risk of exposure to *Aspergillus* species.~~
  - ~~d. Dust accumulation is prevented by daily damp dusting and regular cleaning of ceiling tiles and air-duct grates when rooms are not occupied.~~
  - ~~e. Exposure of high risk residents to potential environmental sources and activities that may aerosolize spores is eliminated (i.e., vacuuming floors and carpets, potted plants).~~
- ~~8. During construction or renovation activities in areas where high risk residents may be exposed:~~
- ~~a. Construct barriers between resident care and construction areas. Barriers must be impermeable to *Aspergillus* sp.~~
  - ~~b. Direct pedestrian traffic from construction areas away from resident care areas.~~
  - ~~c. Clean newly constructed areas before allowing residents to enter the areas.~~
- ~~9. If a case of health-care associated Aspergillosis occurs:~~
- ~~a. Begin a prospective and retrospective review for additional cases.~~
  - ~~b. If evidence of continuing Aspergillosis infection is present, conduct an environmental investigation to determine and eliminate the source.~~
  - ~~c. If an environmental source is not identified, review existing infection control measures and identify potential areas that can be improved.~~
  - ~~d. If an environmental source is identified, perform corrective measures as needed to eliminate the source.~~

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 72-01 F1 Renovation / Construction Infection Control Guidelines

LHHPP 72-01 F11 Classification of Reusable Medical Devices and Processing Requirements

LHHPP 72-05 Employee Influenza Vaccination Policy and Use of Surgical Masks When Vaccination is Declined

LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

LHHPP 73-09 Respiratory Protection Program (RPP)

NPP I2.0 Tracheobronchial Suctioning

NPP I3.0 Tracheostomy Care

CDC 2008 Guideline for Disinfection and Sterilization in Healthcare Facilities

CDC 2003 MMWR Recommendations and Reports, Guidelines for Environmental Infection Control in Health-Care Facilities

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 05/11/01

Notes:

*Aspergillus* spp. are ubiquitous fungi, commonly occurring in soil, water, and decaying vegetation. *Aspergillus* spp. have been cultured from unfiltered air, ventilation systems, contaminated dust dislodged during hospital renovation and construction, horizontal surfaces, food, ornamental plants (607), and recently, water from hospital water system (608). *A. fumigatus* and *A. flavus* are the most frequently isolated *Aspergillus* spp.

## URINARY CATHETERIZATION GUIDELINES

### POLICY:

1. Measures to reduce the incidence of UTIs are directed at reducing the total use and duration of the use of urinary catheters.
- 4.2. For necessary urinary catheter use that has been evaluated and found to have no other alternative, current CDC Guidelines will be followed. ~~the following guidelines are followed.~~

### PURPOSE:

The Infection Control program at Laguna Honda Hospital (LHH) has adopted guidelines for the management of urinary catheterization that are consistent with CDC guidelines and minimize the potential for urinary tract infection (UTI).

### PROCEDURE:

1. The attending physician shall evaluate patients arriving at LHH with indwelling bladder catheters and document the indication for catheterization.
  - a. ~~The primary indication for long-term use of indwelling catheters should be urinary retention, but use for urinary incontinence may infrequently be justified to prevent skin breakdown, allow healing of wounds or pressure sores, for diagnostic or treatment purposes, or for other reasons.~~ Straight catheterization is appropriately used to obtain specimens when the resident is unable to void voluntarily and for intermittent catheterization for conditions such as urinary retention or neurogenic bladder.
2. Catheters must be removed when no longer needed.
3. On the order of a physician, catheters are to be placed without contamination from the other person performing the insertion with avoidance of trauma by the use of sterile lubricant. and the smallest bore catheter consistent with good drainage. (See also Nursing Policy F5.0.) ~~Unless otherwise specified in the order, a size 16 silicone-coated catheter with a 5 ml retaining balloon shall be inserted.~~
4. Hand hygiene should be done immediately before and after any manipulation of the urinary catheter site or apparatus.
5. Maintain closed sterile drainage and unobstructed urine flow. (It may be necessary to temporarily obstruct the catheter for specimen collection). To achieve free flow of urine:
  - a. The catheter and tubing should be kept from kinking.

- b. The collecting bag should be emptied regularly using a separate collecting container for each resident (the draining spigot and non-sterile collecting container should never come in contact).
  - c. Irrigate per physician's order with large-volume sterile syringe and sterile irrigant using aseptic technique for obstruction. The physicians order shall include a specific indication of use.
  - d. Collecting bags should always be kept below the level of the bladder
6. Training of individuals who insert and maintain urinary catheters should emphasize aseptic technique whenever the catheter-resident connection is approached, as well as the system is sampled.
  7. Urinary Catheter Insertion: Insert catheter using aseptic technique and sterile equipment and securing catheter properly to prevent movement and urethral traction.
  8. Specimen Collection: To obtain urine specimen, cleanse sampling port with alcohol and aspirate urine with a syringe. Larger volumes of urine for special analysis should be obtained aseptically from the drainage bag.
  9. Meatal Care: Cleanse the area where the catheter enters the urethral meatus with soap/water and dry well daily.
  10. Catheter Change Interval: Catheters should not be changed routinely and should be changed only if clinically indicated, e.g., due to malfunction or obstruction. A physician's order is required for initial catheter insertion and for catheter changes.
  11. Also refer to LHH P&P file: F5.0, Nursing Management of Residents with Catheters.

**ATTACHMENT:**

None.

**REFERENCE:**

[LHH Nursing Policy F5.0 Nursing Management of Residents with Catheters](#)  
[CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections, 2009](#)~~None.~~

Revised: 16/07/12 (Year/Month/Day)

Original adoption: Est. 05/11/01

## PEDICULOSIS (LICE) MANAGEMENT

### POLICY:

Residents/patients and personnel infected or exposed to lice are evaluated and managed to prevent transmission.

~~The guidelines provide information in the evaluation and management of lice/pediculosis infestation.~~

### PURPOSE:

To provide information in the evaluation and management of lice/pediculosis infestation.

~~Personnel infected or exposed to lice are evaluated and managed to prevent transmission to other residents and personnel.~~

### PROCEDURE:

#### 1. Mode of Transmission

Body lice are spread directly through contact with a person who has body lice or indirectly through shared clothing, beds, bed linens, or towels.

Head lice are transmitted only by:

- a. Direct contact with an infested person
- b. Objects used on the hair such as combs, brushes, uniforms, or hair ribbons.
- c. Clothing such as hats, scarves, coats, sports
- d. Lying on a back, couch, pillow, carpet, or stuffed animal that has recently been in contact with an infected person.
- e. Pubic lice are spread through sexual contact and occasionally by contact with clothing, bed linens, or towels that have been used by an infested person.

#### 2. Description of Lice Infestation

- a. The three types of lice are human parasites: body lice, head lice, and pubic or crab lice, ~~and head lice.~~ There are three forms of lice:
  - i. Nit or head lice eggs
  - ii. Nymph or body louse and

- iii. Adult louse, about the size of a sesame seed, has six legs and is tan to grayish-white.
- b. 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), though these are rare.
  - i. Body lice are parasite insects that live on the body and in the clothing, especially along the inner seams or bedding infested humans.
  - ii. Head lice are parasitic insects found on the heads of people. Head lice are commonly found on the scalp behind the ears and near the neckline at the back of the neck and rarely found on the body, eyelashes or eyebrows.
  - iii. Pubic lice, also called crabs are smaller than body lice, only 1-2 mm in length. Crab lice are found in the genital area of humans.

### 3. Signs and Symptoms:

#### a. Body lice:

- i. Itching and rash are common; both are your body's allergic reaction to the lice bite. Long-term body lice infestations may lead to thickening and discoloration of the skin, particularly around the waist, groin, and upper thighs. Sores on the body may be caused by scratching. These sores can sometimes become infected with bacteria or fungi.

#### ~~b. Pubic lice:~~

- ~~ii. Itching in the genital area. Nits (lice eggs) or crawling lice may be seen.~~

#### ~~e.b.~~ Head lice:

- i. Tickling feeling of something moving in the hair.
- ii. Itching, caused by an allergic reaction to the bites.
- iii. Irritability.
- iv. Sores on the head caused by scratching. These sores can sometimes become infected.

#### c. Pubic lice:

- ii. Itching in the genital area. Nits (lice eggs) or crawling lice may be seen.

#### 4. Diagnosis and Treatment

- a. Upon admission, the skin and hair of all residents will be carefully inspected for possible infestation before the resident is placed in bed. If questionable symptoms (itching, small white substance (nits) on hair shafts or living lice are present, the ~~area supervisor~~ nurse manager/designee and infection prevention and control nurse/officer ~~nurse~~ are to be notified immediately.
- b. Residents with pediculosis are to have their baths scheduled last, after unaffected residents have received their tub baths.
- c. If the ~~nurse manager~~ licensed nurse strongly suspects pediculosis, ~~she~~ the physician will be notified for treatment orders will request the physician to order pediculicidal shampoo and the resident is to have a shampoo to treat nits and lice found on eyebrows.
- d. ~~If only a few nits are found, it may be possible to remove lice and nits with a nit comb. Lice medications should not be used near the eyes.~~
- e. ~~—~~
- f.d. Disposable gloves and long sleeve gown are to be worn when performing the procedure. delousing.
- g. ~~Resident's soiled clothing shall~~ may be washed separately from other residents' clothing in the hot water cycle, followed by and use the high heat ~~hot cycle of the dryer for at least 20 minutes to dry clothes, or be dry cleaned. Items that cannot be laundered, shall be dry cleaned or sealed in a plastic bag and stored for 2 weeks.~~ if the resident has head or pubic lice. Soiled clothing is to be discarded if the resident has body lice.

#### 5. Equipment

- a. Obtain from Pharmacy:
  - i. Pediculicidal medication
- b. Obtain from unit or central ~~ward~~ supply:
  - i. Fine tooth comb
  - ii. Nail clipper
  - iii. Disposable gloves
- c. Obtain from Central Supply:

- i. ~~Isolation gown~~ Disposable gowns

## 6. Staff Precautions:

- a. Hand hygiene is the first line of defense.
- b. Alert all personnel and resident visitors who may come in contact with the resident.
- c. ~~When working in this precautionary environment, S staff are to self-monitor for signs and symptoms of pediculosis. anxiety could cause related symptoms. Nursing LHH staff who continue to have symptoms are to report to the area supervisor or nurse manager/designee to determine if further screening is necessary.~~

### ~~Preparation of Resident:~~

~~Explain procedure to resident.~~

~~Screen for privacy.~~

~~Patient teaching.~~

## 7. Procedure for individual residents ~~admitted with probable pediculosis:~~

- a. Care of Resident
  - i. Staff should ~~Put on~~ wear ~~isolation~~ disposable gowns and ~~disposable~~ gloves.
  - ii. ~~Cut~~ Keep resident's fingernails ~~very~~ short.
  - iii. ~~If an oil-based hair dressing has been used or the hair is very oily, it is recommended that the H hair should be shampooed, rinsed, and dried before medication is applied. Do not use a cream rinse or combination shampoo/conditioner before using lice medicine.~~
  - iv. ~~Apply the prescribed medication onto the affected area according to label instructions and or as directed by the physician.~~
  - v.
  - vi. iv. ~~Work the shampoo thoroughly into hair and allow to remain in place for the time designated in the order or as described in Drug Facts and Comparison.~~
  - vii. v. ~~Rinse hair thoroughly with water.~~
  - viii. vi. ~~Bathe resident per routine bath procedure.~~



~~ix.~~vii. Towel dry hair. Do not blow dry hair.

~~x.~~ Comb the hair with a fine tooth comb to remove any remaining nits. WARNING: Do not wash hair 1-2 days after treatment. If no dead lice are found 8-12 hours after treatment and lice seem as active as before, the medicine treatment may not be working. See your health care provider. Notify the physician for a different medication and follow their treatment instructions. Continue to check all treated persons for 2-3 weeks after you think that all lice and nits are gone there are no signs or symptoms of infestation.

Dress resident in clean gown or pajamas.

~~xi.~~ The resident does not return to his own unit (bedside) until it has been cleaned per procedure.

Report any allergic reaction to physician immediately.

viii. WARNING: Do not wash hair 1-2 days after treatment. If no dead lice are found 8-12 hours after treatment and lice seem as active as before, the treatment may not be working. Notify the physician and follow their treatment instructions. Continue to check all treated persons for 2-3 weeks after there are no signs or symptoms of infestation.

ix. After treatment, check hair every 2-3 days and use a nit comb to remove any nits or lice you see.

x. The resident does not return to his room until it has been cleaned per procedure.

~~xii.~~xi. Retreat in 7-10 days.

xii. Report any allergic reaction to physician immediately.

## 8. Care of Property

- a. If bath tub is used by the resident, nursing shall disinfect the tub with the approved hospitalwide disinfectant and let tub dry for 15 minutes before using again.
- b. Strip linen from resident's bed. Put all linen into double bags. Close the bags securely and place them in the linen chute.
- c. ~~Wash the unit with disinfectant and water according to bed-stripping procedure (Nursing P&P).~~ Disinfect the wheelchair, commode, transport gurney (if used), bed, the bedside table and stand furniture inside and outside the bed room with the approved ~~housewide~~ hospitalwide disinfectant. Include footboard, water

~~cushion, trapeze, and call light bed attachments and call light signal cord, and rubber sheet.~~

~~h.e.~~ \_\_\_\_\_ To kill lice and nits, machine wash all washable clothing that the infested person touched during the 2 days before treatment. Use the hot water cycle to wash clothes. Dry laundry using the high heat cycle for at least 20 minutes. Resident's soiled clothing shall be washed separately from other residents'. Items that cannot be laundered, shall be sealed in a plastic bag and stored for 2 weeks.

d. Usually, only a relatively small number of head or pubic lice will occur away from their normal host, the person. Away from their host, they usually die in 3 days or less; therefore, the resident's personal belongings that cannot be washed or dry cleaned (such as shoes, books, clothing, toilet articles, etc.) should be sealed in a plastic bag for 14 days. ~~Soiled clothing is discarded if the resident has body lice.~~

~~e. Wash with housewide disinfectant and dry the resident's wheelchair, bedside unit furniture, commode and transport gurney (if used).~~

~~f.e.~~ If the resident has a urinary drainage bag or colostomy bag, replace it. Double-bag and discard in a standard waste container. ~~red garbage can.~~

~~g.f.~~ Double-bag disposable materials, including the water pitcher, ~~and~~ cup, toothbrush and used gloves and discard in a standard waste container. ~~in red plastic isolation waste bags. Place them in the red garbage can on porter's porch or closet. Dispense-Provide~~ a new water pitcher, cup and toothbrush.

~~h. Sterilize the resident's emesis basin, toothbrush holder, and oral hygiene cup.~~

~~i.g.~~ Soak personal items such as combs, brushes, hair bands, and barrettes in ~~rubbing alcohol or~~ soapy hot water for one hour.

~~j.h.~~ Notify Housekeeping to remove, double bag, and replace ~~cubicle~~ privacy curtains.

~~k. Also refer to "Lice Infestation"~~

## 9. For in-house residents with signs of pediculosis

a. If there are several residents on a neighborhood ward with pediculosis, the entire neighborhood or household ward-resident and/or staff population may require treatment. ~~be treated as described in the scabies procedure.~~

## 10. Documentation

- a. Medical Record: Record procedure, medications used, and description of resident's skin and reaction of the resident. Record and describe any allergic symptoms.
- b. "Unusual Occurrence Record": Include description of skin observation and medication prescribed. If this is a newly admitted resident, include the name of facility and the unit the resident came from.

**ATTACHMENT:**

None.

**REFERENCE:**

[CDC Resources for Health Professionals, 2015 @  
http://www.cdc.gov/parasites/lice/head/health\\_professionals/index.html](http://www.cdc.gov/parasites/lice/head/health_professionals/index.html)

[73-11 Medical Waste Management Program](#)

~~SFGH Infection Control Manual, 2007.~~

~~LHH Nursing Policies and Procedures Manual, 2000.~~

~~California Dept. of Health Services; Head Lice~~

~~<http://www.cdc.gov/ucidd/dpd/parasites/lice/default.htm>~~

Revised: 16/07/12 (Year/Month/Day)

Original adoption: Est. 05/11/01

## CLOSTRIDIUM DIFFICILE GUIDELINES

### POLICY:

1. LHH will identify and manage Clostridium difficile (C. diff) infection according to this policy and in accordance with Centers for Disease Control (CDC) guidelines and the Nursing Home Quality Campaign goal of reducing C. diff infections.
2. Ongoing prevention of C. diff shall be addressed through surveillance and antimicrobial stewardship efforts along with a rigorous hand hygiene program.  
~~Personnel are provided information and guidelines regarding infections with C. difficile.~~

### PURPOSE:

To prevent, assess and manage ~~LHH has adopted guidelines for evaluation and management to prevent transmission of~~ Clostridium difficile infection in accordance with current guidelines from credible sources.

### PROCEDURE:

1. Care providers shall follow basic essential steps to prevent C. diff infection and colonization such as hand hygiene, consistent use of standard precautions, appropriate use of personal protective equipment (PPE) and judicious use of antibiotics.
2. Contact Precautions shall be observed from the time that new or worsening diarrhea that cannot be contained is noted and shall not be delayed pending culture results, according to LHH guidelines for diarrheal illness and C. diff infection (C1 Alphabetical List of Diseases/ Conditions Requiring Precautions.)
  - a. Provide a private room with private bathroom, as described below.
    - i. A private room with a private bathroom is necessary to prevent the spread of C. diff spores to environmental surfaces during showering and toileting.
    - ii. A closed double or triple room is not adequate due to the risk of spreading spores to shared environmental surfaces such as the toilet and shower area. It is not practical to reliably clean the bathroom with bleach 24/7 prior to another resident entering the bathroom.
    - iii. If a private room with a private bathroom cannot be provided then residents with C. diff infection or colonization may be cohorted in the same room or in closed double or triple rooms.
  - b. Place a Contact Precautions sign on or next to the outside of the door.

- c. Place an isolation cart outside of the room stocked with gowns and gloves at minimum. Add face shields if procedures that may splatter. Remove alcohol based hand wipes from cart.
  - d. Place bleach wipes on cart and use to disinfect high touch surfaces at least daily, such as call light, bed rails, door handles, and faucets.
  - e. Use bleach solution for daily cleaning by EVS staff.
  - f. Wash hands with soap and water only. Alcohol based hand rub is not effective against spores.
  - g. Provide dedicated equipment that is disposable or not removed from the room until Contact Precautions are lifted and the equipment is cleaned with bleach wipes. (e.g., vital signs equipment and ADL assistive devices.)
  - h. Nursing staff will communicate need for contact precautions to resident, visitors, and EVS. Educate as appropriate to the level of contact and understanding.
  - i. Before entering room, wash hands, don gown then gloves.
  - a.j. Before leaving room, remove and discard gloves, then gown, then wash hands.
3. Cultures for C. diff are processed using watery, unformed or loose stool specimen less than 24 hours old in a clean, watertight container without preservative. Refrigerate specimens at 4°C pending testing. (The microbiology lab will not process formed specimens.)
- a. Retesting to verify treatment effect or to screen asymptomatic residents is not advised.
  - b. Specimens are processed using real time PCR, Nucleic Acid Amplification Testing (NAAT) with the Cepheid GeneXpert instrument. NAAT targets chromosomal toxin B genes with a high degree of sensitivity and specificity and rapid results.
  - c. Notify the Infection Prevention and Control Officer (IPCO) of cultures positive for C. diff. IPCO is also informed via daily culture reports.
4. Group activities and non-essential appointments should be postponed while the resident has diarrhea that cannot be easily and reliably contained.
- a. Dialysis Centers do not generally accept residents with active C. diff infection until 48 hours without diarrhea and 5 days of therapy, therefore clinical and lab monitoring to evaluate the need for acute hospitalization and dialysis is necessary.

- b. For essential appointments or transfer to acute, alert the receiving staff, dress resident resident in clean clothing and contain incontinence (i.e. with adult briefs).
- c. Document the need for Contact Precaution under “special considerations” on the nursing Inter-Facility Transfer Record upon discharge or transfer.

4.5. Contact Precautions may be lifted once the resident has completed 5 days of treatment and has had no diarrhea for at least 48 hours.

## ~~2. [Epidemiology and transmission of *Clostridium difficile* associated with diarrhea (CDAD)]~~

~~The incidence of community-acquired CDAD is low, but the risk of acquiring *C. difficile* increases in direct proportion to the length of hospital stay. There is a high incidence of asymptomatic carriers in hospitals. Even the most virulent strains of *C. difficile* produce asymptomatic colonization more often than CDAD. There is little data to support the widespread belief that *C. difficile* is part of the normal, endogenous intestinal flora which proliferates because of the suppression of other flora in the presence of antibiotics. Instead, the data indicate that *C. difficile* is exogenously acquired and a variety of clinical outcomes occur following acquisition. One model for the pathogenesis of CDAD is that hospitalized patients acquire the organism and become colonized; when asymptomatic carriers are subsequently exposed to antibiotics, the risk of CDAD is increased. An alternative model, for which there is supportive data, is that hospitalized patients given antibiotics are subsequently exposed to toxigenic *C. difficile*; of these patients an additional factor, such as host susceptibility or virulence of the *C. difficile* strain, determines whether the patient remains asymptomatic or develops CDAD after a brief incubation period. In this model, if and when asymptomatic colonization is established, the patient is at decreased risk of CDAD.~~

~~The two major reservoirs of *C. difficile* are infected humans and contaminated inanimate objects. Patients with CDAD are more infectious than asymptomatic carriers. Health care workers probably transmit the organism from patient to patient through transient hand carriage, and they may develop hand carriage directly from patients or from inanimate objects in the vicinity of symptomatic patients. Environmental contamination is enhanced by the persistence of *C. difficile* spores, which may be resistant to disinfectants and usual cleaning. Objects such as commodes, rectal thermometers, and telephones have been implicated as potential sources. The epidemiology of *C. difficile* is similar to that of vancomycin-resistant enterococci.~~

### ~~Laboratory tests for *Clostridium difficile*-associated diarrhea~~

~~The proper laboratory specimen for diagnosis is at least 1 ml single, fresh (less than 24 hours old), watery, unformed or loose stool specimen (not rectal swabs). The specimen should be submitted in a clean, watertight container (without preservative). Submitting multiple specimens does not increase the likelihood of finding a positive~~

~~by a significant percentage and is not cost-effective for routine practice, but may be useful when the laboratory tests are negative but the diarrhea persists. Testing stools for asymptomatic patients is not clinically useful and is not recommended.~~

~~Deliver the specimen to Microbiology Lab immediately after collection or hold at 4°C until delivery. An enzyme immunoassay method is used to detect *C. difficile* Toxin A. Specimens with absorbance values greater than or equal to the positive cutoff value are positive for *C. difficile* Toxin A. Specimens with absorbance values less than or equal to the negative cutoff are negative. The presence of toxin in specimens with absorbance values between the negative and positive cutoff values is indeterminate. Another specimen must be obtained and tested.~~

~~In various evaluation of the EIA assay, sensitivity ranged from 87-95% and specificity ranged from 95-98%. The result must be interpreted in conjunction with clinical findings and other laboratory data. A negative result does not exclude the possibility of CDAD.~~

### ~~3. Screening for *Clostridium difficile*~~

~~Surveillance cultures of asymptomatic residents or screening cultures of new admissions for *C. difficile* are not routinely indicated, even if the resident has fecal incontinence.~~

### ~~4. Infection Control recommendations for residents with CDAD~~

- ~~a. For residents with CDAD, it is preferable to place them in single room or semi-private room cohorted with other residents with the same infection, especially if the resident's hygiene is poor. If not possible, then place such resident(s) next to low risk residents who are ambulatory, well nourished, no open wounds, and no invasive devices, not on high steroid or immunosuppressive therapy.~~
- ~~b. Since objects may be involved in transmission of *C. difficile*, common use equipment such as thermometers and stethoscopes, commode, toilet should not be shared with uninfected or non-cohorted patients.~~
- ~~c. Allowable activities should only be in clinic appointments like radiology, consults. Before participation in allowable activities, resident's dressing and incontinent brief/diapers should be clean, change if needed and patient is dressed in clean clothing. Incontinent residents should be securely diapered.~~
- ~~d. When diarrhea ceases, the infected resident may be moved to a non-private room and cohorting may be discontinued. He/she may resume all communal activities. Follow-up stool cultures are not necessary to release from enteric precautions or private room/cohorting.~~



~~e. Health care workers should employ appropriate barrier precautions, i.e., enteric (stool) isolation and handwashing when caring for such patients. This includes gloves and gowns for any significant resident contact. (Insignificant contact would occur if a staff member briefly entered the room to leave a tray of food and had no other interaction with the patient). Hand washing must be performed after gloves are removed.~~

~~f. Disinfection of the room and potentially contaminated objects should be performed using housewide disinfectant. The disinfection should include environmental surfaces, such as bedside tables, bed rails, and objects that may be reused, such as stethoscopes.~~

~~5. Transfer of residents from Laguna Honda Hospital to acute care facilities and vice-versa.~~

~~6. If detected, colonization with C. difficile should not prevent the transfer of an individual between facilities if the transfer is medically indicated. Patients should not be held in a facility waiting for colonization to clear if the C. difficile colonization is the only reason to hold the patient.~~

#### ~~7. Outbreaks of CDAD~~

~~8.6. An outbreak of C. diff infection is defined as three (3) or more cases of C. diff infection (CDI) occurring in the same area/ unit of the facility within a period of seven (7) days or less. An outbreak of CDAD is defined as: three (3) or more cases of clinically significant, facility acquired CDAD occurring in the same general area within a period of seven (7) days.~~

~~a. Notify the Infection Prevention and Control Officer.~~

~~b. Cohort infected residents and implement consistent staffing.~~

~~c. Implement Contact Precautions as for an individual case.~~

~~a.d. Report to SFDPH Communicable Disease Prevention and Control unit at (415) 554-2830 within 24 hours if outbreak occurs during weekend or evenings. (Reporting is done by IPCO during usual business hours.)~~

~~b. Provide education and monitoring on proper hand hygiene, standard precautions, and contact precautions. In this instance, Infection Control should be notified. If feasible, there should be cohorting of infected residents, and staff should not crossover to uninfected residents. Once there is clinical resolution of the infection after treatment, no reculture is needed to remove from cohort. (An outbreak is likely to be caused by transmission of organisms by staff and a breakdown in the use of standard precautions.) Therefore, an intense education program for staff should ensure with rigorous supervision of hand washing and use of gloves and gowns. If after these procedures are done and there continue~~



~~to be new cases of clinically significant CDAD, an epidemiologist or the state or local health department should be notified.~~

**ATTACHMENT:**

None.

**REFERENCE:**

~~Hogenauer, C, Hammer, HF, Kregis, GJ, and Reisinger, EC. Mechanisms and management of antibiotic-associated diarrhea. Clinical Infectious Diseases, 1998; 27:702-710.~~

~~Johnson, S. & Gerding, DN. Clostridium difficile-associated diarrhea. Clinical Infectious Diseases, 1998; 26:1027-1036.~~

~~Gerding, DN, Johnson, S, Peterson, LR, Mulligan, ME, & Silva, J. Clostridium difficile-associated diarrhea and colitis. Society for healthcare epidemiology of America position paper. Infection Control and Hospital Epidemiology, 1995; 16:459-477.~~

~~LHHPP 72-01 B1 Standard Precautions~~

~~LHHPP 72-01 B2 Hand Hygiene~~

~~LHHPP 72-01 B5 Transmission Based Precautions and Resident Room Placement~~

~~LHHPP 72-01 C1 Alphabetical List of Diseases/ Conditions with Required Precautions~~

~~APIC, 2008, Guide to the Elimination of Clostridium difficile in Healthcare Setting, from APIC Elimination Guide, 2008~~

~~CDC Advancing Excellence, C. difficile Infection Prevention Assessment Checklists, updated September 15, 2015, available at~~

~~http://www.cdc.gov/longtermcare/prevention/index.html~~

~~Nursing Home Quality Campaign, Advancing Excellence in America's Nursing Homes,~~

~~Infection Goal: Reduce C. diff Infection, available at https://www.nhqualitycampaign.org~~

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 05/11/01 (Year/Month/Day)

## GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

### POLICY:

Laguna Honda Hospital (LHH) 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 working at LHH, 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. Resident TST

- i. 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.
- ii. A two-step TST shall be administered to residents 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.
- iii. In uninfected residents, a positive result on any future TST shall be interpreted as a skin test conversion.
- iv. New residents with positive TST results shall be referred to their attending physician for treatment recommendations.
- v. Residents with a positive TST and prior BCG vaccine shall be considered to have latent tuberculosis infection (LTBI).

b. Health Care Worker TST

- i. 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.
- ~~i~~.ii. A two-step TST shall be administered to 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.
- ~~ii~~.iii. In uninfected HCWs, a positive result on any future TST shall be interpreted as a skin test conversion.
- iv. New HCWs with positive TST results shall be referred to their healthcare provider or the local health department for treatment recommendations.
- ~~iii~~.v. HCWs with a positive TST and prior BCG vaccine shall be considered to have latent tuberculosis infection (LTBI).

~~2. 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).~~

### 3.2. 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 infectious 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 four4 drug TB regimen shall be initiated.

vi. Room Placement

- If the resident is “suspected” to have active TB disease per the physician’s clinical judgement, the resident must be placed in respiratory isolation per Cal OSHA ATD standard.
- If the physician is ruling out disease that s/he does not think is “probable”, then sputum induction can be done in the resident’s room without violating the Cal OSHA ATD standard. ~~(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 respiratoryan isolation room. The case mustwill 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.—Treatment 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.

4.3. 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 for completing this annual requirement 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 health requirement non-compliances 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 thfor their ei overdue for 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.

#### 5.4. 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.

#### 6.5. Record Keeping and Retention

a. Effective January 2016, r~~Resident 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 prot~~  
~~-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.

#### 7.6. 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.

#### ~~8.7.~~ 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 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

[SFPDH Communicable Disease Control and Prevention, TB Control, Information for Medical Providers available <http://sfcdcp.org/tbinfoforproviders.html>](#)

Revised: ~~05/11/01~~, 15/11/09, 16/03/08 (Year/Month/Day)

Original adoption: est. 05/11/01

## **PRE-EMPLOYMENT AND ANNUAL SCREENING OF EMPLOYEES/NEW EMPLOYMENT GUIDELINES**

### **PURPOSE:**

~~To minimize the potential for exposing patients and other health care providers to communicable diseases, all Laguna Honda Hospital (LHH) employees are evaluated for communicable diseases prior to beginning employment.~~

### **POLICY:**

1. Pre-employment and annual health assessments are required for all LHH personnel in accordance with the California Title XXII regulations.

### **PURPOSE:**

Personnel are evaluated for the presence of and immunity to communicable diseases to reduce the potential for exposing residents and health care providers to communicable disease.

### **PROCEDURE:**

1. Prior to placement in a for all work assignments, Zuckerberg San Francisco General/General (ZSFG) Hospital Occupational Health Services (OHS) provides A a physical examination and medical history and immunization/immune status screening for all personnel, which will include an assessment for the presence of active or latent infectious diseases.

~~history is obtained for all personnel to include an assessment for the presence of active or latent infectious diseases at San Francisco General Hospital (SFGH) Occupational Health Services (OHS).~~

Tuberculosis screening is performed for all employees (see Guideline for Prevention and Control of Tuberculosis, B4 ~~TB Control Plan, and Infection Control Policy titled "Tuberculosis Screening/Infection/Exposure in Personnel"~~).

- 1.2. Proof of immunity, or immunizations, immunizations are initiated, for the following infectious diseases is required at S ZFGH OHS, and f Followed up at will occur at LHH Employee Health Service (EHS) as necessary:

- ~~Rubella immunization or proof of immunity is required.~~
- ~~Measles immunization or proof of immunity is required.~~
- Mumps immunization or proof of immunity is required.
- e.d. Varicella immunization or proof of immunity is required.

- Hepatitis B (immunization is offered to all and, if refused, a declination must be signed and filed in the employee health record)
- 2.3. Tetanus/ diphtheria/ acellular pertussis (Tdap) initial immunization and booster is are offered to all and, if refused, a declination must be signed and filed in the employee health record.
4. Influenza immunization is offered annually, "in season" for all health care workers (HCW's). (HCW's 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.
- 3.5. Prospective employees determined to NOT have immunity to rubella, measles, or varicella must initiate the vaccine series prior to reporting to work. Continuation or hiring effor employment is dependent upon completion of the vaccine series.
- 4.6. Current employees who did not complete the screening and immunization program above at the time of their original date of hire are also required to demonstrate immunity to rubella, measles, mumps, and varicella and to undergo immunization as needed to acquire immunity.
- 5.7. For employees who are unable to demonstrate immunity to rubella, measles, mumps, or varicella and who have medical contraindications(s) to immunization, employment will be considered on a case-by-case basis.
- 6.8. For employees who work in select, high-risk areas, additional immunizations may be recommended and made available.
- 7.9. Annual health assessment for all personnel working at LHH Skilled Nursing Facility (SNF) in accordance with California Title 22 regulations and includes the following:
- a. Tuberculosis screening according to policy B4, Guideline for Prevention and Control of Tuberculosis. Annual evaluation of immunization needs are assessed on a case-by-case basis and appropriate vaccines are offered.
- 8.10. Documentation is maintained within the Employee Health Service.
- 9.11. Compliance is reported to the Infection Control Committee not less than annually.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 72-01 Infection Control Manual, B4 Guidelines for Prevention and Control of Tuberculosis

ZSFG Infection Control Policy 5.01 Infectious Disease Screening and immunization Status

Revised: 16/07/12 (Year/Month/Day)

Original adoption: Est. 05/11/01

## RENOVATION / CONSTRUCTION INFECTION CONTROL GUIDELINES

### POLICY:

1. The Infection Control Committee (ICC) shall be consulted by ~~facility~~ Facility services Services during preconstruction ~~regarding~~ planning for facility renovation and construction projects.
2. Pre-construction planning shall ~~provide for~~ include an Infection Control Risk Assessment (ICRA) which considers the resident population in the project areas and the extent, duration and hazards of the proposed construction according to current Centers for Disease Control (CDC) and Association for Practitioners in Infection Control and & Epidemiology (APIC) guidelines.

### PURPOSE:

1. To ensure that dust and other microbial contamination is minimized during ~~all the~~ work phases of construction/renovation projects.
2. To ensure that the design of ~~patient resident~~ care and other areas ~~will~~ facilitate the desired infection control practices as defined by completion of the Infection Control Risk Assessment (ICRA).
3. To minimize infectious risks associated with internal renovation projects in ~~patient resident~~ care areas, and that the ~~following necessary~~ controls and interventions are in place.

### PROCEDURE:

#### 1. PROJECT PLANNING

The Infection Prevention & Control ~~(IC) Officer~~ and Workplace Safety Departments ~~will~~ shall be advised by the ~~Facilities~~ Facility Services Department of plans for renovation and/or new construction. ICRA's shall be a part of integrated facility planning, design, construction and commissioning activities; and ~~will~~ shall ~~be~~ be conducted during the early planning phase of a project, before construction begins; and continue through project construction and commissioning. Life Safety requirements must also be met. (Refer to Facility Services Policy LS-6, Life Safety Management: Building Standards.)

- a. A multidisciplinary team that includes Infection Control, Workplace Safety, Clinical Staff, and ~~Facilities Management~~ Facility Services ~~will~~ shall conduct a proactive ICRA during the design and planning phase for all demolition, renovation, and new construction projects. The scope of the project may require other subject matter experts to be involved.

- b. After completing the ICRA, precautions ~~will~~ shall be taken according to the matrix reflecting the risk level of the ~~patient~~ resident population and the hazard level of the construction work. A complete field review of ~~all~~ infection control implications ~~will~~ shall be conducted before any demolition or construction begins.
- c. Specific areas of consideration for Infection Control include:
  - i. Determine if or how patient care area(s) closure will occur.
  - ii. Traffic patterns for ~~patients~~ residents, health care workers, and visitors.
  - iii. ~~Patient-Resident~~ area risk assessment; criteria for emergency work interruptions (stop and start processes).
  - iv. Planning for air handling and water systems/plumbing as appropriate.
  - v. Education: for whom and by whom.
  - vi. Dust control expectations for subcontractors before start, as needed.
  - vii. Transport and approval for disposal of waste materials.
- d. ICRA expectations ~~will~~ shall be incorporated into initial project agreements to ensure contractor accountability.

## 2. CONTRACTOR DUST CONTROL PROCEDURES

Contractor must provide dust control procedures to Workplace Safety Department for review and approval.

- a. Renovation areas must be isolated from ~~patient~~ resident-occupied areas using "airtight" barriers to eliminate any airflow of particles into patient areas. ~~All-c~~ Critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area ~~will~~ shall be completed before beginning any construction work. ~~All-P~~ Porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) ~~patients- residents~~ with at least one coat of a cleanable/washable no or low-VOC paint.
- b. Temporary construction barriers and closures above ceilings shall be dust tight. A ceiling-to-floor sealed plastic barrier, enclosing the ladder, ~~must~~ shall be constructed to contain the dust whenever more than one ceiling tile is to be removed within a ~~patient~~ resident care area.
- c. Whenever work is performed in which dust contamination has occurred, the area is to be cleaned as soon as possible using a vacuum cleaner equipped with a High Efficiency Particulate Air (HEPA) filtration system or damp mopping procedure to

prevent the “tracking” of dust throughout the facility. Sweeping and dry mopping are never appropriate in a hospital environment. Floor “tack” or “sticky” mats are to be placed in areas of construction crew egress, and replaced when they lose their ability to capture dust and debris from a user’s shoe soles.

- d. If negative pressure is required (based on ICRA), negative pressure must-shall be established and continuously maintained to the renovation work area enclosure to contain dust generated by work activities inside the enclosure until all work is complete.
- e. Negative pressure must-shall be monitored continuously. Recording manometers shall be used to display and record pressure differentials automatically. Pressure differential records must-shall be collected and reviewed by project personnel on a daily basis, as evidenced by their initials along with the date and time of the review, and maintained available on site for review by infection control and health and safety personnel upon request.
- f. Construction waste and demolition debris shall be covered and sealed during transport, and transport equipment cleaned prior to removal from the work area. Transport is to be done during the lowest activity periods. A schedule will-shall be drafted to inform contractor of times to avoid transport area. Elevators ~~should~~ shall be avoided for debris transport. If an elevator ~~must be~~ is used, it ~~should~~ shall be designated for construction use only.
- g. Removal of construction barriers and ceiling protection shall be done outside of normal working hours unless otherwise authorized in advance of activities. Areas will be wet mopped and/or HEPA vacuumed following barrier removal. ~~All vacuuming~~ Vacuuming outside of negative pressure areas will-shall be performed with a HEPA-filtered vacuum which has been aerosol challenge tested prior to initial use at the LHH site.

### 3. MONITORING:

- a. LHH reserves the right to monitor for bioaerosols, general particle (dust) counts, or other project specific contaminants or indicators in the vicinity of the project.
  - b. If monitoring results exceed background levels, or other infection control risk becomes apparent, the Contractor will-shall be notified to correct the condition immediately to avoid fines and work stoppage as described below:
    - i. All work may be stopped on a project whenever a hazardous material/waste deficiency, infection control deficiency, or dust control complaint exists.
    - ii. The Contractor shall take immediate action to correct the deficiencies.
- ~~● Failure of the Contractor to correct such deficiencies may result in corrective action taken by the Hospital and deducting the cost from the contract.~~

#### 4. ENFORCEMENT:

- a. Determination of violations ~~will~~ shall be based on periodic Infection Control Rounds in collaboration with the Industrial Hygienist and Facility Services staff. Findings will be reported to the Infection Control Committee. Photographs ~~will~~ may be taken to document ~~each~~ violation(s), as feasible.
- b. The Contractor, Project Manager/Coordinator, LHH ~~Facilities~~ Facility Services Department and others as appropriate, ~~will~~ shall be ~~notified~~ informed in writing.
- c. A record of all ICRA violations ~~will~~ shall be maintained.
- d. ~~Violations of ICRA requirements may result in fines, as specified in the construction contract, and may affect status as a responsible contractor for bidding future work~~

#### 5. Documentation

- a. Primary representatives ~~will~~ shall be identified on the Infection Prevention & Control Construction Permit Clearance Checklist (Attachment B), which contains an overview of the ICRA results and the required precautions from Infection Prevention & Control Officer, Workplace Safety, ~~Facilities Management~~ Facility Services, the Contractor, a project manager/coordinator, and others as deemed appropriate.
- b. The ~~permit~~ Clearance Checklist ~~will~~ shall be signed by the ~~lead~~ Infection Prevention & Control Officer or designee ~~representative~~ and a copy ~~will~~ shall be maintained at the work site.

#### ATTACHMENTS:

- Appendix A: Infection Control Risk Assessment (ICRA).  
Appendix B: Infection Prevention & Control Construction Permit

#### REFERENCE:

- LHH Facility Services Policy LS-6: Life Safety Management, Building Standards  
Centers for Disease Control and Prevention's "*Guidelines for Environmental Infection Control in Health-care Facilities*" (2003)  
Association for Practitioners in Infection Control & Epidemiology (APIC) State-of-the-Art Report: "*The role of infection control during construction in health care facilities.*" (2000)

Revised: 15/07/12 (Year/Month/Day)  
Original adoption: Est. 05/01/01



## Appendix A: Infection Control Risk Assessment

CDPH Infection Prevention During Construction, retrieved 5/27/15 @

<http://www.cdph.ca.gov/programs/hai/Documents/Slide-Set-14-Environment-of-Care.pdf>

### Step One:

Using the following table, *identify* the Risk categories by construction type (Type A-D)

<b>Type A</b>	<b>Non-Invasive Activities and Inspection</b> <ul style="list-style-type: none"><li>• Removal of ceiling tiles for visual inspection (limit 1 tile per 50 square feet)</li><li>• Painting (but not sanding)</li><li>• Wall covering, electrical trim work, minor plumbing, other activities that do not generate dust, require cutting of walls, nor accessing ceilings</li></ul>
<b>Type B</b>	<b>Small scale, short duration activities that create minimal dust</b> <ul style="list-style-type: none"><li>• Installation of telephone and computer cabling</li><li>• Access to crawl spaces</li><li>• Cutting walls or ceiling where dust migration can be controlled</li></ul>
<b>Type C</b>	<b>Work that generates moderate to high levels of dust, requires demolition, or removes fixed building components or assemblies</b> <ul style="list-style-type: none"><li>• Sanding walls for painting or wall covering</li><li>• Removal of floor coverings, ceiling tiles, and casework</li><li>• New wall construction</li><li>• Minor duct work, electrical work above ceilings, major cabling activities</li><li>• Any activity that cannot be completed within a single work shift</li></ul>
<b>Type D</b>	<b>Major demolition and construction projects</b> <ul style="list-style-type: none"><li>• Activities that require consecutive work shifts</li><li>• Require heavy demolition or removal of a complete cabling system</li><li>• New construction</li></ul>

**Step Two:**

Using the following table, *identify* the Risk categories by patient care areas that will be affected. If more than one risk group will be affected, select the higher risk group:

Low Risk	Medium Risk	High Risk	Highest Risk
<ul style="list-style-type: none"> <li>• Office Areas</li> <li>• Dining Hall</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiology</li> <li>• Echocardiography</li> <li>• Endoscopy</li> <li>• Nuclear Medicine</li> <li>• Physical Therapy</li> <li>• Radiology</li> <li>• Respiratory Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• CCU</li> <li>• Emergency Dept.</li> <li>• Labor &amp; Delivery</li> <li>• Specimen Labs</li> <li>• Nursery</li> <li>• Outpatient Surg.</li> <li>• Pediatrics</li> <li>• Pharmacy</li> <li>• PACU</li> <li>• Surgical Units</li> </ul>	<ul style="list-style-type: none"> <li>• Burn</li> <li>• Cardiac Cath Lab</li> <li>• Sterile Central Supply</li> <li>• ICU</li> <li>• Medical Units</li> <li>• NPIR</li> <li>• Oncology</li> <li>• Operating Room</li> <li>• Any area caring for Immunocompromised patients</li> </ul>

**Step Three:**

Identify the Class of Mitigation Activities (below) as determined by the construction type (from step one) and the patient /area type (from step 2) using the chart below.

Patient Risk Level	Construction Activity Type			
	Type A	Type B	Type C	Type D
Low	I	II	II	III/IV
Medium	I	II	III	IV
High	I	II	III/IV	IV
Highest	II	III/IV	III/IV	IV

**NOTE: INFECTION CONTROL APPROVAL** is required when the Construction Activity and Risk Level indicate that **CLASS III** or **CLASS IV** Infection Control procedures are to be utilized.

**Classes I – IV** require the infection control precautions outlined on the following page.

**IC Matrix Class of Precautions: Construction Project by Patient Risk**

	During Construction Project	Upon Completion of Project
<b>CLASS I</b>	<p><b>Execute work to minimize raising dust from construction operations:</b></p> <ol style="list-style-type: none"> <li>1. Use methods to minimize creating/disturbing dust from construction operations.</li> <li>2. Using hospital-approved disinfectant, mist tiles and work surfaces to control dust before beginning work.</li> <li>3. Immediately replace a ceiling tile displaced for visual inspection. HEPA-vacuum obvious dust collection.</li> </ol>	<ol style="list-style-type: none"> <li>1. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.</li> </ol>
<b>CLASS II</b>	<p><b>Actively work to prevent airborne dust from dispersing into atmosphere:</b></p> <ol style="list-style-type: none"> <li>1. Seal unused doors with duct tape.</li> <li>2. Block off and seal air vents.</li> <li>3. Place dust mat at entrance/exit of work area.</li> <li>4. Remove or isolate building HVAC system in areas where work is being performed.</li> <li>5. Provide active means to prevent airborne dust from dispersing into atmosphere.</li> <li>6. Using hospital-approved disinfectant</li> </ol>	<ol style="list-style-type: none"> <li>1. Wipe work surfaces with disinfectant.</li> <li>2. Contain construction waste before transport in tightly covered containers.</li> <li>3. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.</li> <li>4. Restore HVAC system in areas where it was isolated or disconnected.</li> </ol>

<b>CLASS III</b>	<p><b>Remove or isolate HAC system in area where work is being performed to prevent contamination of duct system:</b></p> <ol style="list-style-type: none"> <li>1. Follow precautions for class I and II, above, and:</li> <li>2. Before construction begins, complete all critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit).</li> <li>3. All porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) patients with at least one coat of a cleanable/washable no or low-VOC paint.</li> <li>4. Maintain negative air pressure with work site utilizing HEPA equipped air filtration units.</li> <li>5. Contain construction waste before transport in tightly covered containers.</li> <li>6. Cover transport receptacles or carts. Tape covering unless solid lid.</li> </ol>	<ol style="list-style-type: none"> <li>1. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.</li> <li>2. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.</li> <li>3. Vacuum work area with HEPA filtered vacuums.</li> <li>4. Wet mop area with disinfectant.</li> <li>5. Restore HVAC system in areas where it was isolated or disconnected.</li> </ol>
<b>CLASS IV</b>	<p><b>Isolate HVAC where work is being done to prevent contamination of duct system:</b></p> <ol style="list-style-type: none"> <li>1. Adhere to ALL precautions above, and:</li> <li>2. Seal holes, pipes, conduits, and punctures appropriately.</li> <li>3. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.</li> <li>4. All personnel entering work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work area.</li> <li>5. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.</li> </ol>	<ol style="list-style-type: none"> <li>1. Remove barrier material carefully to minimize spreading of dirt and debris associated with construction.</li> <li>2. Contain construction waste before transport in tightly covered containers.</li> <li>3. Cover transport receptacles or carts. Tape covering unless solid lid.</li> <li>4. Vacuum work area with HEPA filtered vacuums.</li> <li>5. Wet mop area with disinfectant.</li> <li>6. Remove isolation of HVAC system in areas where work is being performed.</li> <li>7. Clean or replace HVAC filters and verify appropriate ventilation parameters for the area have been re-established.</li> <li>8. Flush the main water system to clear</li> </ol>

**Step 4.** Identify the areas surrounding the project area and assess the potential impact. Apply steps 1-3 for adjacent areas and follow identified precautions.

Unit Below:	Unit Above:	Lateral area 1:	Lateral area 2:	Area Behind:	Area in Front:
Risk Group	Risk Group	Risk Group	Risk Group	Risk Group	Risk Group

**Other Decision Making Considerations:**

1. Identify specific site of activity e.g., patient rooms, medication room, etc.
2. Identify issues related to: ventilation, plumbing, electrical in terms of the occurrence of probable outages.
3. Identify containment measures, using prior assessment. What types of barriers? (e.g, solid wall barriers) Will HEPA filtration be required?  
  
(Note: Renovation/construction area shall be isolated from the occupied areas during construction and shall be negative with respect to surrounding areas.)
4. Consider potential risk of water damage. Is there a risk due to compromising structural integrity? (e.g., wall, ceiling, roof)
5. Work hours: Can or will the work be done during non-patient care hours?
6. Do plans allow for adequate number of isolation/negative airflow rooms?
7. Do the plans allow for the required number & type of hand washing sinks? Does the infection control staff agree with the minimum number of sinks for this project? (Construction company to verify against American Institute of Architects (AIA) Guidelines for Healthcare Facilities.)
8. Does the infection control staff agree with the plans relative to clean and soiled utility rooms?
9. Plan to discuss the following containment issues with the project team.  
e.g., traffic flow, housekeeping, debris removal (how and when)

**Appendix B: Infection Prevention and Control Construction Permit Clearance Checklist (double sided form)**

<b>Infection Prevention &amp; Control Construction <u>Permit Clearance Checklist</u></b>				
Contractor Performing Work:				
Location of Construction:			Project Start Date: <del>Estimated Duration:</del>	
Project Coordinator/ Manager:			Estimated Duration:	
<u>Industrial Hygienist:</u>				
<u>Infection Prevention and Control Officer:</u>				
Assessment Performed By: (List all key participants)				
<u>Chief Operations Officer</u>		<u>Industrial Hygienist</u>		
<u>Project Coordinator / Manager</u>		<u>Infection Prevention and Control Officer</u>		
<u>Director of Quality Management</u>		<u>Director of Environmental Services</u>		
<u>Chief Nursing Officer</u>		<u>Department Managers affected by project</u>		
<u>Infection Control Committee Chair</u>		<u>Contractor performing work</u> —		
_____				
Determine Resident Risk/ Construction Categories: Check one box in each of the categories listed below. When more than one box is applicable, check the higher level. NOTE: <u>Refer to Appendix A for a complete an</u> explanation of categories <u>may be found in the LH HWP and</u> Renovation / Construction Guidelines				
<u>Patient Resident</u> Risk Level	Construction Activity Type			
	Type A	Type B	Type C	Type D
<b>Low</b>	I	II	II	III/IV
<b>Medium</b>	I	II	III	IV
<b>High</b>	I	II	III/IV	IV
<b>Highest</b>	II	III/IV	III/IV	IV
<del>Authorizing Infection Prevention &amp; Control Officer or Designee Representative:</del>			<del>Date:</del>	
<del>Move this to the bottom of the form</del>				
_____				
_____				
<del>Printed Name/ Title</del>			<del>Signature</del>	
Exceptions/ Additions to the permit are noted by attached memoranda:		Initials:	Date:	

Updated Precautions Classification (required if any changes occur in Patient Risk Group or Construction Activity):	Initials:	Date:
<u>Infection Prevention &amp; Control Officer or Designee:</u>  <hr/> <hr/> <div style="display: flex; justify-content: space-between;"> <span>Printed Name/ Title</span> <span>Signature</span> </div>		<u>Date:</u>

**IC Matrix Class of Precautions: Construction Project by Patient Risk**

	During Construction Project	Upon Completion of Project
<b>CLASS I</b>	<b>Execute work to minimize raising dust from construction operations:</b> 1. Use methods to minimize creating/disturbing dust from construction operations. 2. Using hospital-approved disinfectant, mist tiles and work surfaces to control dust before beginning work. 3. Immediately replace a ceiling tile displaced for visual inspection. HEPA-vacuum obvious dust collection.	1. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.
<b>CLASS II</b>	<b>Actively work to prevent airborne dust from dispersing into atmosphere:</b> 1. Seal unused doors with duct tape. 2. Block off and seal air vents. 3. Place dust mat at entrance/exit of work area. 4. Remove or isolate building HVAC system in areas where work is being performed. 5. Provide active means to prevent airborne dust from dispersing into atmosphere. 6. Using hospital-approved disinfectant	1. Wipe work surfaces with disinfectant. 2. Contain construction waste before transport in tightly covered containers. 3. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area. 4. Restore HVAC system in areas where it was isolated or disconnected.

<b>CLASS III</b>	<p><b>Remove or isolate HAC system in area where work is being performed to prevent contamination of duct system:</b></p> <ol style="list-style-type: none"> <li>1. Follow precautions for class I and II, above, and:</li> <li>2. Before construction begins, complete all critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit).</li> <li>3. All porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) patients with at least one coat of a cleanable/washable no or low-VOC paint.</li> <li>4. Maintain negative air pressure with work site utilizing HEPA equipped air filtration units.</li> <li>5. Contain construction waste before transport in tightly covered containers.</li> <li>6. Cover transport receptacles/ carts. Tape covering unless solid lid.</li> </ol>	<ol style="list-style-type: none"> <li>1. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.</li> <li>2. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.</li> <li>3. Vacuum work area with HEPA filtered vacuums.</li> <li>4. Wet mop area with disinfectant.</li> <li>5. Restore HVAC system in areas where it was isolated or disconnected.</li> </ol>
<b>CLASS IV</b>	<p><b>Isolate HVAC where work is being done to prevent contamination of duct system:</b></p> <ol style="list-style-type: none"> <li>1. Adhere to ALL precautions above, and:</li> <li>2. Seal holes, pipes, conduits, and punctures appropriately.</li> <li>3. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.</li> <li>4. All personnel entering work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work area.</li> <li>5. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.</li> </ol>	<ol style="list-style-type: none"> <li>1. Remove barrier material carefully to minimize spreading of dirt and debris associated with construction.</li> <li>2. Contain construction waste before transport in tightly covered containers.</li> <li>3. Cover transport receptacles or carts. Tape covering unless solid lid.</li> <li>4. Vacuum work area with HEPA filtered vacuums.</li> <li>5. Wet mop area with disinfectant.</li> <li>6. Remove isolation of HVAC system in areas where work is being performed.</li> <li>7. Clean or replace HVAC filters and verify appropriate ventilation parameters for the area have been re-established.</li> <li>8. Flush the main water system to clear</li> </ol>



## INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

### POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) injury and Illness Prevention Program (IIPP) is established to provide a safe and healthy work environment for all LHH employees.

This document is intended to be ever-evolving and will reflect our progress toward the continuous improvement of the health, safety, and welfare of our employees.

### PURPOSE:

The purpose of the IIPP is to implement and maintain effective procedures for preventing workplace injury and illness in accordance with California Occupational Safety and Health Standards, California Code of Regulations (CCR) Title 8, Section 3203 and Section 1509.

### PROCEDURE:

#### 1. Responsibilities

- a. *The Manager of the Laguna Honda ~~Industrial Hygienist~~ Department of Workplace Safety and Emergency Management shall be the IIPP administrator and have the authority and responsibility for administering and maintaining the overall program and for updating the program periodically. The LHH—Industrial Hygienist Department of Workplace Safety and Emergency Management will also be responsible for the following:*
  - i. Providing initial and ongoing health and safety training to employees during hospital-wide orientation and periodic in-services.
  - ii. Chairing the Occupational Safety and Health (OSH) Committee.
  - iii. Providing assistance to Department Managers as requested in implementing the IIPP. This might include assessing hazards, training employees, and investigating accidents.
  - iv. Reviewing all incident reports and investigating when necessary.
  - v. Analyzing and summarizing injury/illness data. Reports will be provided to PIPS twice per year and to the Executive Team once per year.
  - vi. Making recommendations for injury/illness prevention based on hazards and injury/illness data.

- b. *The Laguna Honda Occupational Safety and Health (OSH) Committee's* primary mission is to provide support to enhance the Laguna Honda ~~Occupational Safety and Health Program~~ IIPP (see Appendix A). The Committee will serve to facilitate the anticipation, recognition, evaluation, and control of workplace hazards in a timely and effective manner so as to prevent occupational illness and injury. In addition to this primary mission, the Occupational Safety and Health Committee will encourage employees to participate in the safety process and to communicate openly about health and safety concerns without fear of reprisal.
- c. *Department Managers* will be responsible for implementing the components of the IIPP within their work areas. This will include the following:
  - i. Identifying risks and informing workers of risks and how to minimize them.
  - ii. Providing job-specific health and safety training.
  - iii. Promoting a positive atmosphere of open communication regarding safety and health that is free from harassment, discrimination, and fear of reprisal.
  - iv. Making sure that employees follow safety procedures.
  - v. Conducting incident investigations and identifying corrective actions.
  - vi. Take appropriate disciplinary action when employees do not comply with Laguna Honda health and safety policies and procedures.
- d. All employees will:
  - i. Comply with Laguna Honda health and safety policies and procedures;
  - ii. Use and maintain required personal protective equipment (PPE), including respirators;
  - iii. Promote and facilitate a safe and healthy environment for themselves and their co-workers;
  - iv. Report injuries, illnesses, and incidents involving a risk to health and safety immediately to their supervisor;
  - v. Report any potential safety or health risk immediately to their supervisor, including perceived physical or emotional risk;
  - vi. Abate risks immediately when possible and safe to do so;

- vii. Not undertake a task or operate equipment unless authorized and trained to do so safely and to ask for assistance when they do not understand how to complete a task safely;
  - viii. Attend required health and safety training and medical surveillance examinations.
- e. The Laguna Honda Executive Team will:
- i. Provide the necessary resources to implement and maintain an effective IIPP.
  - ii. Assign Department Managers responsibilities for implementing the IIPP in their areas of responsibility.
  - iii. Calendar at least annually a review of a report from the LHH ~~Industrial Hygienist~~ Department of Workplace Safety and Emergency Management including analyses of injury and illness data.
  - iv. Review recommendations from the Industrial Hygienist and the Laguna Honda OSH Committee.
  - v. Take action as appropriate to minimize health and safety risks.

## 2. Communication

- a. Laguna Honda promotes a system of open communication between management and staff in which staff are encouraged to report hazardous conditions and near-misses without fear of reprisal. Employees are required to report any hazards immediately to their supervisors, who are expected to investigate and mitigate the hazards.
- b. All Laguna Honda employees will receive health and safety training, including information about this IIPP during hospital-wide orientation and in periodic in-service trainings throughout the year.
- c. Department Managers will be instructed on the hazards in their work areas either during Leadership Forum or individually by the Laguna Honda Industrial Hygienist.
- d. Employees will receive job-specific health and safety training within their departments on initial job assignment and additionally when:
  - i. Assigned to a new job or task for which they have not been trained previously;
  - ii. New substances, processes, procedures, or equipment are introduced and pose a new hazard;

- iii. A previously unrecognized hazard is brought to the attention of the Supervisor.
- e. Departmental safety meetings will be held periodically and/or time will be allocated in regular staff meetings to discuss health and safety issues.
- f. Monthly meetings of the Laguna Honda OSH Committee provide an open forum for communication across functional areas regarding occupational health and safety issues. Any Laguna Honda employee is welcome to attend these meetings.
- g. A health and safety bulletin board on the first floor of the main Administration building will be maintained by the Industrial Hygienist. Information about the LHH Occupational Safety and Health Program, including a schedule of OSH Committee meetings and the Cal OSHA Injury log will be posted.
- h. The main page of the Laguna Honda Intranet site accessible to all employees shall have an Occupational Safety and Health button linking users to safety and health resources including injury reporting procedures and safety data sheets.

### **3. Hazard Identification and Evaluation**

- a. Hazards will be identified primarily by Department Managers, but may also be identified in any of the following ways:
  - i. Health and safety surveys conducted by the LHH Industrial Hygienist either randomly or at the request of an employee or Manager.
  - ii. Supervisors introducing new tasks, substances, or equipment into their area.
  - iii. Employee(s) bringing the hazard to the attention of the Supervisor, Department Manager, Industrial Hygienist, or OSH Committee.
  - iv. [Employee\(s\) using the Workplace Hazard Reporting Form available on the Laguna Honda intranet Occupational Safety and Health button and in hard copy in the Admin building lobby. \(Appendix B\)](#)
- b. New hazards will be evaluated by the supervisor, the Laguna Honda Industrial Hygienist, or the Laguna Honda OSH Committee as appropriate to determine necessary safety procedures and training.

### **4. Reporting and Investigation of Occupational Injuries and Illnesses**

- a. Notification
  - i. All incidents involving health and safety hazards will be reported immediately to the supervisor of the employee involved.

- In the case of injuries that do not require immediate emergency treatment, the employee will report the injury to his/her supervisor prior to seeking medical treatment.
- In the case of injuries that do require immediate emergency medical treatment, the employee must inform the supervisor as soon as possible. Unless they are medically unable to do so, employees must inform their supervisors on the same day/shift of the injury.
- In the case of occupational illnesses, it may be difficult to associate a specific event or exposure. The employee will report the illness to the supervisor as soon as there is a suspicion of diagnosis of an occupational illness.
- In the case of needle sticks and bloodborne pathogen exposures, the incident should be reported to the supervisor in the same manner as other occupational injuries and illnesses. In addition, there is a 24-hour phone hotline which allows employees to obtain more specific information on follow-up for this type of exposure.

b. Medical Treatment

- i. The supervisor shall assist the employee in obtaining prompt medical treatment of occupational injuries and illnesses, as necessary. The employee may proceed to any one of the twelve approved service sites for San Francisco City and County employees. A list of these service sites can be found in Appendix C.
  - An ambulance shall be called for transport if the employee's condition is serious or medically unstable.
  - If the employee's condition is not serious and is medically stable ~~or medically unstable~~, the supervisor shall arrange for the employee's safe and appropriate transportation to designated treatment facilities. ~~Taxi vouchers are available in Administration and the Nursing Office to Supervisors to provide to employees who are unable to drive to the doctor, but who do not require emergency transport.~~
  - Incident forms do not have to be completed prior to the employee seeking medical treatment.

c. Documentation

- i. On the same day/shift of an employee reporting or a supervisor having knowledge of an occupational injury or illness, the Supervisor (not the employee) will complete the following forms found in Appendix D. These forms

are available as fillable pdf forms on the Laguna Honda intranet Occupational Safety and Health button; and fax or send them to the DPH OSH Section:

- ~~Complete a~~ Supervisor's Incident Investigation Form (SIIR)
  - ~~Employer's~~ Report of Occupational Injury or Illness (Form 5020), ~~and the~~
  - ~~Employee's~~ Claim for Worker's Compensation Benefits form (Form DWC-1).
- ii. If the employee loses work time or seeks medical treatment, the employee fills out ~~must complete and sign~~ their section of the Form DWC-1.
  - iii. Fax all ~~three~~ completed forms to DPH OSH at 415-554-2562 as soon as possible and then send a hard copy in interoffice mail.
  - iv. If all the details of the incident ~~are not known or~~ cannot be obtained quickly or are not known due to the employee's unavailability, submit the form with as much information as possible and ~~to~~ submit a written supplement to the form as soon as possible when you have more detail.
- d. Fatality / Serious Injury
- i. In the event of a fatality or a serious occupational injury or illness (See Definition section on "Cal/OSHA Reportable Incident"), requiring hospitalization:
  - ii. ~~The~~ attending supervisor will complete the LHH Supervisor Serious Injury/Fatality Tool/Cal OSHA Reporting Checklist (Appendix B).
  - iii. The supervisor will contact the LHH Industrial Hygienist/Safety Officer, Human Resources Department Administrator on Duty, or the Nursing Operations Manager/Supervisor as indicated on the Cal OSHA Reporting Checklist/LHH Supervisor Serious Injury/Fatality Tool.
  - iv. ~~the~~ The LHH Safety Officer/Industrial Hygienist, Human Resources Department Administrator on Duty, or the Nursing Operations Manager/Supervisor will notify the nearest Cal OSHA office immediately @415-972-8670.

**ATTACHMENT:**

Appendix A: Charter and Membership Structure of the Laguna Honda Occupational Safety and Health Committee Charter

Appendix B: Workplace Hazard Reporting Form

Appendix C: List of Workers' Compensation Designated Clinics

Appendix D: Injury Reporting Checklist and Paperwork

Appendix C: Serious Injury/Fatality Tool

**REFERENCE:**

California Occupational Safety and Health (OSH) Standards, Title 8, *California Code of Regulations (CCR)*, section 3203

Revised: 95/05/01, 98/12/24, 99/11/22, 00/03/02, 08/04/29, 14/03/25, 14/05/27, 16/07/12  
(Year/Month/Day)

Original adoption: 92/05/20

**Appendix A:**

**Laguna Honda Hospital and Rehabilitation Center  
Occupational Safety and Health Committee Charter**

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to providing a safe and healthy workplace for all employees. The primary mission of the Occupational Safety and Health Committee is to provide support to enhance the Laguna Honda Occupational Safety and Health Program.

The Committee will serve to facilitate the anticipation, recognition, evaluation, and control of workplace hazards in a timely and effective manner so as to prevent occupational illness and injury.

In addition to this primary mission, the Occupational Safety and Health Committee will encourage employees to participate in the safety process and to communicate openly about health and safety concerns without fear of reprisal.

The Occupational Safety and Health Committee will meet monthly to:

- Evaluate employee safety suggestions;
- Review injury and incident reports and investigations;
- Assess hazardous conditions brought to the attention of any committee member;
- Act as a problem-solving group to help with the identification and control of hazards;
- Help to formulate and disseminate policies, practices and procedures that promote safety, health and wellness.



**Appendix B: Workplace Hazard Reporting Form**

**LAGUNA HONDA HOSPITAL INJURY & ILLNESS PREVENTION PROGRAM  
HAZARD REPORTING FORM**

Laguna Honda employees and building occupants may use this form to report any unrecognized, or uncontrolled safety issues to the Occupational Safety and Health (OSH) Committee. The Workplace Safety staff and/or the OSH Committee will investigate the reported hazard to determine if mitigations are needed. This form can be submitted anonymously if desired. Employees are advised that it would be illegal for an employer to take any action against an employee in retaliation for exercising their right to report hazards.

**HAZARD**

<p><b><u>Unsafe Condition or Practice:</u></b></p> <p><b><u>Specific Location:</u></b></p> <p><b><u>Suggestion for Improving Safety:</u></b></p>
--

**Has this matter been reported to your supervisor?**    Yes   No

**Would you like to be notified when this issue has been addressed?**   Yes   No  
**If yes, please provide contact information.**

**YOUR INFORMATION (OPTIONAL)**

<p><b><u>Name:</u></b></p> <p><b><u>Department:</u></b></p> <p><b><u>Phone:</u></b></p> <p><b><u>E-mail:</u></b></p>
--

This form may be dropped in the box across from the Volunteer Office on the ground floor of the Administration building, or you may send it directly to the Laguna Honda Industrial Hygienist via interoffice mail.

## **Appendix C:** **Workers' Compensation Designated Clinics**

When an employee has an occupational injury or illness, the first concern is to ensure that the employee receives timely medical care. If the employee needs medical care, the supervisor should direct the employee to a Workers' Compensation Designated Clinic.

### **For Injuries Occurring During Normal Business Hours:**

#### **St. Francis Treatment Room**

1199 Bush Street, Suite 160

Hours: 7:30 a.m. to 5:30 p.m., Monday through Friday

Telephone: (415) 353-6305

#### **AT&T Clinic – St. Francis Health Center (at the Ballpark)**

24 Willie Mays Plaza

Hours: 7:30 a.m. to 5:00 p.m., Monday through Friday

Telephone: (415) 972-2249

#### **Kaiser Occupational Health Clinic (Opera Plaza)**

601 Van Ness Avenue, Suite 2008

(Inside the Opera Plaza building, 2nd floor)

Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday

Telephone: (415) 674-7000

#### **California Pacific Medical Center – Davies Campus**

Castro & Duboce Streets

Hours: 7:00 a.m. to 11:00 a.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday

Telephone: (415) 600-6600

#### **San Francisco International Airport Medical Clinic**

International Terminal, Level 3, "A" Side

(Departures Level, Pre-Security)

Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday and

9:00 a.m. to 1 p.m., Saturday

Telephone: (650) 821-5600

#### **US Healthworks**

1893 Monterey Road, Suite 200

San Jose, CA

Hours: 7:00 a.m. to 7:00 p.m., Monday through Friday

Telephone: (408) 288-3800

#### **Valley Care Occupational Health Clinic**

5565 W. Los Positas Blvd. Suite 150

Pleasanton, CA

Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday

Telephone: (925) 416-3562

### **For Injuries Occurring After Normal Business Hours:**

#### **San Francisco General Hospital Emergency Department**

1001 Potrero Ave

San Francisco, CA

Telephone: (415) 206-8111

**California Pacific Medical Center – Davies Campus Emergency Department**

Castro and Duboce Streets  
Telephone: (415) 600-0600

**Kaiser Permanente Medical Center – San Francisco**

Urgent Care Clinic  
2238 Geary Blvd., 8th Floor S.E.  
Hours: 5:00 p.m. to 9:00 p.m.

**Kaiser Permanente Medical Center – San Francisco**

Emergency Department  
2200 O'Farrell Street at Baker  
Hours: 9:00 p.m. to 8:00 a.m.  
Telephone: 202-2000

**Saint Francis Memorial Hospital Emergency Department**

1100 Bush Street, between Hyde and Leavenworth Streets  
Telephone: 353-6300

**Appendix D: Injury Reporting Checklist and Paperwork for Supervisors**

**Laguna Honda Supervisor’s Injury Reporting Checklist**

**Whenever a Laguna Honda employee reports a workplace injury or near miss incident, the supervisor must do the following before the end of the shift:**

- Complete the Supervisor’s Incident Investigation Report (DPH SIIR).
- Complete the State of California Employer’s Report of Occupational Injury or Illness (DPH OSH Form 5020).
- Give the employee a blank Workers’ Compensation Claim Form (DWC-1) and Notice of Potential Eligibility.

**1. If the employee is going to seek medical treatment for an injury or illness:**

- Have the employee complete and sign the top section of the DWC-1. You must complete the Employer section (bottom half).
- Fax all three forms (SIIR, 5020, and DWC-1) to DPH OSH at 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.
- Provide the employee with the list of workers’ compensation designated clinics. The employee must seek treatment at one of these facilities unless they have submitted a pre-designation form to HR to see their personal physician.

**2. If the employee does not intend to seek medical treatment:**

- Fax the SIIR and 5020 **ONLY** to DPH OSH at 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.
- If they change their mind and turn in a completed DWC-1, follow the instructions in section 2.

**3. If the reported incident involves exposure to blood, body fluids, or other infectious material:**

- Complete section 1 and the first two steps in section 2 above.
- Instruct the employee to call the Needlestick Hotline at 415-469-4411.
- Send the employee for follow up care to SFGH Occupational Health Services.

**4. If the reported incident involves exposure to an aerosol transmissible disease (ATD), such as TB:**

- Follow instructions in section 1, but substitute the ATD Exposure Report for the SIIR.
- Follow instructions in section 2 or section 3 as appropriate.

**5. If the injury is fatal or serious (employee is sent to a hospital):**

- Complete the first page of the LHH Supervisor Serious Injury/Fatality Tool to determine whether or not Cal/OSHA notification is required. **This must be done immediately.**

**If you answered yes to any questions on the first page of the tool:**

- Complete the second page.
- Follow the instructions for contacting the Industrial Hygienist, AOD, or Nursing Supervisor and provide them with a copy of the completed tool **within 2 hours of the incident, regardless of the time of the incident.**

**If you did not answer yes to any questions on the first page, no further action is required.**

## RESPIRATORY PROTECTION PROGRAM (RPP)

### POLICY:

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

### PURPOSE:

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

### PROCEDURE:

#### 1. Program Scope

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

In some circumstances, Laguna Honda staff may not be required to wear respiratory protection to comply with SFDPH policies, Cal OSHA standards, or CDC Guidelines, but may choose to wear a respirator for an additional level of protection. Such voluntary use is allowed for employees who are otherwise included in the RPP, and have been medically cleared, ~~trained, and fit tested for~~ and trained to use a respirator provided by the facility. These employees will be provided with the information provided in Appendix D of the Cal-OSHA Respiratory Protection Standard Title 8, Section 5144 (Appendix B of this document).

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

The following employees who are performing the following tasks may either be required, or may choose to wear respirators and will be included in the RPP:

**a. Employees who are directly involved in any of the following resident care activities**

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

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

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

**c. Pharmacy Technicians**

- i. Cleaning up spills of hazardous drugs
- ii. Using bleach to clean compounding areas in the pharmacy.

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

- i. Functioning in an airborne isolation room with the presence of infectious disease agents.

- ii. Performing routine tasks in close proximity to residents with known or suspected ATDs.
- iii. Performing routine tasks during which there is exposure to airborne contaminants below permissible exposure limits, which the employee chooses to reduce further with the voluntary use of a respirator.

**e. Health and SafetyWSEM Staff**

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

## 2. Program Objectives

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

- a. Adherence to the requirements of the Cal-OSHA Respiratory Protection Standard Title 8, Section 5144, Section 5199 Aerosol Transmissible Diseases, 1529 Asbestos, and Section 1532.1 Lead.
- b. Designation of an appropriate RPP Administrator to oversee and implement this program.
- c. Providing a detailed outline of procedures to:
  - i. Select appropriate respiratory protective equipment,



- ii. Medically evaluate employees,
- iii. Train and fit test employees,
- iv. Provide appropriate record keeping and program evaluation.

**3. Program Administrator**

The Laguna Honda Senior Industrial Hygienist or designee shall be the RPP Administrator and will be responsible for implementation and review of the program.

**4. Respiratory Protective Equipment Selection**

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

Employee Group	Task or Duty	Selected Respirator	Comments
Resident Care Providers and Support Staff	Performing routine patient care, cleaning, or maintenance tasks in airborne isolation rooms or in the presence of residents with known or suspected ATD	N95 Filtering Facepiece Respirator	Employees are required to wear at least an N95 respirator for protection from ATDs transmissible via the airborne route (AirIDs). LHH employees may choose to use an N95 respirator for protection against ATDs categorized as transmissible via droplets.
<u>Facility Services Staff</u>	<u>Performing routine tasks resulting in exposure to nuisance dusts below permissible exposure levels</u>	<u>Filtering Facepiece Respirator</u>	<u>This use is voluntary</u>
Resident Care Providers	Performing high hazard procedures as defined in the ATD Exposure Control Plan.	Powered Air Purifying Respirator (PAPR) with HEPA filters	No one except the care providers performing the procedure should be present.
<u>Facility Services Staff</u>	Performing <u>building repair and maintenance</u> work that could result in exposure to hazardous airborne contaminants.	Half mask respirator or PAPR with the following cartridges: HEPA filters (P100) for class III asbestos work; Organic vapor cartridges for exposure to paint, solvents, oils, greases; Combination organic vapor/dust cartridge for spray painting.	Respirator use is required for Class III Asbestos work. Any employee doing Class III asbestos work who cannot be fit tested for a negative pressure respirator must wear a PAPR. Other repair and maintenance work is not expected to result in exposures exceeding any Cal OSHA permissible exposure limits and the use of respirators for these tasks is voluntary.

<u>EVS Floor Crew</u>	<u>Stripping and waxing floors</u>	<u>Half mask respirator with organic vapor or combination organic vapor/acid gas cartridge</u>	<u>This use is voluntary</u>
Industrial Hygienist, <u>Senior Industrial Hygienist</u>	Monitoring LHH employee or contractor activities in areas where respirator use is required	N95 filtering facepiece. Half face respirator with appropriate cartridges.	
Facility Services <u>Staff, Pharmacy Techs.</u> and <u>Senior Industrial Hygienist</u>	Spill response	Half face respirator or PAPR with appropriate cartridge for spilled material.	Certain designated LHH employees may respond to small chemical spills of known materials that are not expected to result in an oxygen deficiency or exposures greater than 10 times the PEL for any substance. No LHH employee will enter an IDLH atmosphere or attempt to respond to a spill or release of an unknown material.

The respiratory protection equipment selection process is based on:

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

## 5. Medical Evaluations

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

### a. Initial Medical Clearance Evaluations

Initial medical evaluation includes:

- i. All nNew Laguna Honda employees ~~in the job classifications listed in Appendix A~~ shall be medically evaluated for clearance to use respiratory protection during

- their pre-employment exam at the Zuckerberg San Francisco General Hospital (ZSFG) Occupational Health Clinic Service (OHS) using responses to questionnaires required by Cal OSHA.
- Employees in non-resident care classifications shall be evaluated using the RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE found in Appendix CB.
  - Resident care job classifications shall be evaluated using the ALTERNATE RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: found in Appendix CB.
- ii. The PLHCP at ~~San Francisco General Hospital (SFGH)~~ the ZSFG OHS shall complete the Medical Clearance Certificate (Appendix DC) and forward it to the Laguna Honda Senior Industrial Hygienist or designee.
  - iii. If an employee is not cleared for the use of a particular type of respirator, they must not be assigned to tasks that require the use of that respirator. However, if an employee is cleared to use a PAPR, but not a negative pressure respirator, they may perform tasks requiring a negative pressure respirator ~~using if~~ provided with a PAPR.

#### **b. Subsequent Medical Evaluations**

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

- i. Employee reports medical signs/symptoms or a medical condition to a Supervisor that are related to his or her ability to use a respirator.
- ii. Information from the RPP, including observations made during the fit testing or the program evaluation, which indicates the need for employee medical re-evaluation.
- iii. The PLHCP determines that an evaluation is needed. It is DPH policy that this will include a re-evaluation every 5 years.
- iv. The employee requests re-evaluation due to a change in health status.

### **6. Training**

Employees included in the RPP due to being in a job classification listed in Appendix A shall complete an initial training on respiratory protection before being assigned to a task requiring the use of a respirator. The initial training that will be completed during departmental orientation will be broken into two parts. ~~One part~~ Part I will be delivered

live or on the e-Learning system and the other will be hands-on training during fit testing.

**a. ~~The eLearning training module~~ Part I shall include:**

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

**b. The hands-on training shall include:**

- i. How to inspect the respirator.
- ii. How to don and doff the respirator.
- iii. How to perform positive and negative pressure seal checks.

## 7. Fit Testing

- a. Employees shall only be fit tested if they have been medically cleared for respirator use prior to the fit test. If they are not cleared for respirator use, they must not be assigned to tasks that require respirator use.
- b. Employees who are required to regularly wear a respirator shall be fit tested annually by ~~the Industrial Hygienist or other staff designated by the Industrial Hygienist~~ WSEM or other staff trained by WSEM. New employees shall not be assigned to tasks requiring the use of a respirator until they have been fit tested.
- c. In addition to annual testing, employees shall be re-tested if any of the following occurs:
  - i. Different respiratory protective equipment is introduced.
  - ii. The employee reports an improper fit.
  - iii. There is a significant change in the size or shape of an employee's face.

- d. Employees who do not regularly wear respirators, but who may be required to wear one during an emergency or surge shall be fit tested as needed prior to wearing the respirator.
- e. In accordance with Cal-OSHA, fit testing for a negative pressure respirator shall not be performed on any employee who has facial hair (including stubble, beard, mustache, sideburns) that interferes with the face to facepiece seal of the respirator. OSHA Compliance Directive CPL 2.120 defines the presence of facial hair to be “more than one day’s growth”.
- f. Quantitative fit testing using a TSI PortaCount Pro or qualitative fit testing using Bitrex or Saccharin will be performed according to the protocols in Appendix A of Title 8 CCR Section 5144.
- g. Employees shall be given the opportunity to choose from several brands and sizes of respirators.
- h. Fit test results shall be documented on the Fit Test Certificate found in Appendix [ED](#).
- i. The Industrial Hygienist or designee shall maintain a list of employees who have been fit tested within the last year showing the make and size of respirator for which they have passed the fit test. The list shall be updated at least quarterly and sent to Department Managers whose employees are required to use respirators.

## 8. Respiratory Protective Equipment Use

### a. Requirements for Use

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

### b. Procedures Before and During Use

- i. Employees must inspect equipment for integrity before use.
- ii. Employees must perform user seal checks prior to use.
- iii. Employees using PAPR units must perform an airflow test prior to use.

- iv. Corrective eyewear and other personal protective equipment must be worn in a manner that does not interfere with the respirator seal.
- v. An employee must exit the work area to a designated safe zone if:
  - Respiratory protective equipment malfunctions or becomes damaged.
  - They experience an increased ~~d~~ in breathing resistance.
  - They detect chemical cartridge breakthrough.

## 9. Storage, Maintenance, And Disposal

### a. Storage

- i. N95 filtering facepiece respirators for use in patient care and cleaning of isolation rooms will be available from Central Supply and will be stored in the ante rooms of the isolation rooms when occupied by a resident with suspected or confirmed ATD. They may also be stored at the nurses' station or equipment room in each of the units.
- ii. Facility Services, EVS, WSEM, and Pharmacy employees who will be required to wear reusable air purifying respirators will be issued their own half face elastomeric respirator, which they will store in a plastic bag in their locker or work area.
- ~~iii. The Industrial Hygienist will also be issued a half face respirator, which will be kept in a plastic bag in his/her office.~~
- ~~iv.~~iii. PAPRs may~~will~~ be stored in isolation room ante rooms, the Facility Services Department, ~~the Nursing Department~~, and the Industrial Hygienist's Office.

### b. Maintenance, Cleaning and Disposal

- i. Half face elastomeric respirators
  - Elastomeric respirators will be inspected before and after use to ensure all parts are working and have not been damaged. Damaged respirators will either be repaired or replaced by ~~the Director of Facility Services~~WSEM.
  - Employees who have been issued their own elastomeric facepiece will be responsible for cleaning the respirator with a disinfectant wipe or mild soap and water after each use. Respirators will be air dried and returned to a zip lock bag for storage.

- After use, cartridges will be ~~removed and~~ placed in zip-lock bags.
  - Chemical cartridges will be replaced if they become damaged or when the wearer perceives breakthrough of the contaminant.
  - Filter cartridges will be replaced when the wearer notices an increased resistance to breathing.
- ii. N95 filtering facepieces
- N95s are designed for single use and will be discarded when removed after exposure to a confirmed or suspected case of ATD. Re-use will only be permitted in the event of a shortage during a disease outbreak as per the ATD Exposure Control Plan.
  - N95s that are used voluntarily or for non-infectious dusts may be re-used for the duration of a shift as long as they are not damaged.
- iii. PAPRs
- PAPRs will be maintained fully charged in their storage locations so that they are ready for use.
  - Air flow will be checked before and after use of PAPRs.
  - Filter cartridges on PAPRs~~s~~ will be changed when they are damaged or when air flow drops below 6 cubic feet per minute (CFM).
  - PAPR blowers will be cleaned with disinfectant wipes after each use. PAPR hoods will be discarded after use in atmospheres contaminated with asbestos or an ATD.

## 10. Program Review

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

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

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

## 11. Record Keeping

### a. Written Program

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

### b. Medical Clearance Records

- i. Confidential records including medical clearance questionnaires will be kept in the employees' employee health medical files in accordance with the DPH Privacy Policy and Title 8 CCR Section 3204 for the duration of employment plus 30 years.
- ii. Medical Clearance Certificates will be entered into the DPH OSH Respiratory Protection Database by ~~the Industrial Hygienist~~ WSEM or designee. Hard copies will be kept on file in ~~the the health and safety~~ WSEM office

### c. Training Records

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

### d. Fit test Records

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



**ATTACHMENT:**

Appendix A: Job Classifications Included in the LHH RPP

Appendix B: [Information for Employees Using Respirators When Not Required Under the Standard](#)

[Appendix C: Medical Questionnaires](#)

Appendix [D](#): Medical Clearance Certificate

Appendix [E](#): Fit Test Certificate

**REFERENCE:**

Cal-OSHA Aerosol Transmissible Disease Standard, 8 CCR Section 5199

Cal-OSHA Asbestos Standard, 8 CCR Section 1529

Cal-OSHA Lead Standard, 8 CCR Section 1532.1

Cal-OSHA Respiratory Protection Standard, 8 CCR Section 5144

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 13/09/05

## **APPENDIX A**

### **Job Classifications Included in the LHH RPP**

2230	Physician Specialist	2922	Sr Medical Social Worker
2232	Senior Physician Specialist	2924	Medical Social Work Supv
2302	Nursing Assistant	<a href="#">2930</a>	<a href="#">Psychiatric Social Worker</a>
2303	Patient Care Assistant	3417	Gardener
2305	Psychiatric Technician	6138	Industrial Hygienist
2312	Licensed Vocational Nurse	<a href="#">6139</a>	<a href="#">Senior Industrial Hygienist</a>
2320	Registered Nurse	7120	Buildings/Grounds Maint Supv
2322	Nurse Manager	7203	Buildings/Grounds Maint Supv
2323	Clinical Nurse Specialist	7205	Chief Stationary Engineer
2324	Nursing Supervisor	7334	Stationary Engineer
2390	CPD Technician	7335	Sr Stationary Engineer
2406	Pharmacy Helper	7342	Locksmith
2409	Pharmacy Technician	7344	Carpenter
2424	X-Ray Laboratory Aide	7345	Electrician
2430	Medical Evaluations Assistant	7346	Painter
2450	Pharmacist	7347	Plumber
2454	Clinical Pharmacist	7524	Institution Utility Worker
2468	Diagnostic Imaging Tech II	P103	Special Nurse
2469	Diagnostic Imaging Tech III		
2536	Respiratory Care Practitioner		
2542	Speech Pathologist		
2548	Occupational Therapist		
2550	Sr Occupational Therapist		
2554	Therapy Aide		
2555	Physical Therapist Assistant		
2556	Physical Therapist		
2558	Senior Physical Therapist		
2574	Clinical Psychologist		
2576	Supv Clinical Psychologist		
2583	Home Health Aide		
2585	Health Worker I		
2587	Health Worker III		
2588	Health Worker IV		
2593	Health Program Coordinator III		
2622	Dietetic Technician		
2624	Dietitian		
2626	Chief Dietitian		
2736	Porter		
2738	Porter Assistant Supervisor		
<a href="#">2738</a>	<a href="#">Porter Supervisor 1</a>		
<a href="#">2785</a>	<a href="#">Assistant General Svcs Mgr</a>		
<a href="#">2903</a>	<a href="#">Eligibility Worker</a>		
<a href="#">2908</a>	<a href="#">Hospital Eligibility Worker</a>		
<a href="#">2909</a>	<a href="#">Hospital Eligibility Supervisor</a>		
2920	Medical Social Worker		

**APPENDIX B:**

**Information for Employees Using Respirators When Not Required  
Under the Standard**

## Appendix B

This information is provided free of charge by the Department of Industrial Relations from its web site at [www.dir.ca.gov](http://www.dir.ca.gov). These regulations are for the convenience of the user and no representation or warranty is made that the information is current or accurate. See full disclaimer at [http://www.dir.ca.gov/od\\_pub/disclaimer.html](http://www.dir.ca.gov/od_pub/disclaimer.html).

### **Subchapter 7. General Industry Safety Orders** **Group 16. Control of Hazardous Substances** **Article 107. Dusts, Fumes, Mists, Vapors and Gases** **§5144. Respiratory Protection.**

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index  
New query](#)

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### **Appendix D to Section 5144: (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard**

#### **Guide to Respiratory Protection at Work**

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Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

**APPENDIX CB**

**MEDICAL QUESTIONNAIRES**

**Department of Public Health**  
**RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: LHH**  
(As per Appendix C to § 5144; California Code of Regulations Title 8)

**Can you read?**                      **Yes**                       **No**

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

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

1. Today's Date \_\_\_\_\_
2. Your Name: \_\_\_\_\_ DSW: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_ Date of Birth: \_\_\_\_\_
4. Sex (circle one)            **Male / Female**
5. Your height \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your weight \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire.  
  
    (    ) -    - \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire?            Yes             No
11. Check the type of respirator you will use (you can check more than one category):
  - a.  N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - b.  Other type (for example, half-or full-facepiece type, powered-air purifying, supplied air, self-contained breathing apparatus).
12. Have you worn a respirator?            Yes             No
13. If "yes", what type(s)? \_\_\_\_\_

**PART A. SECTION 2.** Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check “yes” or “no” to answer each question).

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

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

	YES	NO
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

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

	YES	NO
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problems that you've been told about		



4. Do you **currently** have any of the following symptoms of pulmonary or lung illnesses?

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

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

	YES	NO
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other problems that you've been told about		

6. Have you **ever** had any of the following cardiovascular or heart symptoms?

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

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

	YES	NO
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
e. Other medical condition(s) please describe: _____		

8. If you've ever used a respirator, have you **ever** had any of the following problems?

(If you've never used a respirator, check the following space... ... and go to question 9).

	YES	NO
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problems that interferes with your use of a respirator		

9. Would you like to talk to the health professional who will review this questionnaire?

Yes  No

**Department of Public Health**  
**ALTERNATE RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: LHH**  
(As per Appendix B to § 5199; California Code of Regulations Title 8)

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**To the PLHCP:** Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

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

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

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

**Today's date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DSW:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Your age (to nearest year):** \_\_\_\_\_

**Sex (circle one):**    Male      Female

**Height:** \_\_\_\_\_ ft. \_\_\_\_\_ in.    **Weight:** \_\_\_\_\_ lbs.

**Phone number** where you can be reached (include the Area Code): ( ) \_\_\_\_\_

The best time to phone you at this number: \_\_\_\_\_

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

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

N, R, or P disposable respirator (filter-mask, non-cartridge type only).

Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA). **(fill in type here)**        PAPR    

**Have you worn a respirator (circle one):**            Yes      No

If "yes," what type(s): \_\_\_\_\_

**Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").**

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

	Yes	No
Allergic reactions that interfere with your breathing		
Claustrophobia – fear of closed in spaces		

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

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

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

	Yes	No
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity		
Pain or tightness in your chest that interferes with your job		
Any other symptoms that you think might be related to heart or circulation problems		

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

	Yes	No
Breathing or lung problems		
Heart trouble		
Nose, throat or sinuses		

Are your problems under control with these medications? Yes No

**5. If you've used a respirator, have you ever had any of the following problems while respirator is being used?**

*(If you've never used a respirator, check the following space and go to question 6:) \_\_\_\_\_*

	Yes	No
Skin allergies or rash		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator		

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

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PLHCP Signature

\_\_\_\_\_  
Date

APPENDIX DC

**MEDICAL CLEARANCE CERTIFICATE**

## DPH Medical Clearance Certificate

Human Resources, in conjunction with the supervisor/manager, completes Part 1 of this form. Basic information for all DPH employees who may need to wear respiratory protection for infectious agents in case of an emergency is included. If employees wear other types of respiratory protection, the supervisor/manager must add additional information to the form.

### PART 1: To Be Completed By HR & Supervisor / Manager

Employee Name:	Last Name	First Name	DOB:	
Employee Address:				Social Security #
Supervisor Name:	Last Name	First Name	Phone#:	
Supervisor Address:				

#### Use This Key to Specify Employee Respirator Type(s) & Working Conditions

<b>Respirator Types</b>	Facepiece Filtering (N95/100) Respirator Half Mask Air Purifying Respirator Full Face Air Purifying Respirator	Powered Air Purifying Respirator (PAPR) Self Contained Breathing Apparatus (SCBA)
<b>Duration</b>	8 to 12 hours 4 to 8 hours	1 to 4 hours Less than 1 hour
<b>Use Frequency</b>	Regularly (daily) Frequently (few times / week) Occasionally (few times / month) Rarely (few times / year) No Regular Use – Special Circumstances Only for Protection Against Infectious Agents	
<b>Work Effort Level</b>	Light (ex: sitting / standing, performing light arm work) Moderate (ex: walking, moderate lifting) Heavy (ex: strenuous work, shoveling)	
<b>Additional Personal Protective Equipment (PPE)</b>	e.g. Gloves/Gowns/Face Shield	
<b>Extremes in Temperature or Humidity</b>	Is the employee working in environments with extreme temperature or humidity?	

Respirator Type(s)	Duration	Frequency of Use	Level of Work Effort	Additional PPE	Extremes in Temperature or Humidity
<i>N95 or PAPR</i>	<i>8 Hrs</i>	<i>No Regular Use</i>	<i>Moderate</i>	<i>Gloves, Gowns, Faceshield</i>	<i>No</i>

### Part 2: To Be Completed By Health Care Provider

The named individual is:

- Medically qualified to wear the respirator(s) listed above
- Medically qualified to wear the respirator(s) listed above with the following restrictions:

- Not medically qualified to wear the respirator(s) listed above
- Alternate respiratory protective equipment that could be used:

Health Care Provider: NAME/TITLE: \_\_\_\_\_  
Signature: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_ Date for Re-Evaluation: \_\_\_\_\_

**Laguna Honda Hospital**

**MEDICAL CLEARANCE FORM**

<b>Employee Name:</b>		<b>DSW:</b>	
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**Part I: To be completed by RPP Administrator or employee's supervisor**

Other: \_\_\_\_\_

**Job Category(s):** \_\_\_\_\_  
\_\_\_\_\_

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

**Respirator Type(s):** \_\_\_\_\_  
\_\_\_\_\_

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

**Duration of Use:**

- <1 hour \_\_\_\_\_
- 1-4 hours
- 4-8 hours
- 8-12 hours

**Frequency of Use:**

- Regularly (daily) \_\_\_\_\_
- Frequently (few times per week)
- Occasionally (few times per month)
- Rarely (few times per year)
- No regular use — only in a surge or emergency

Other: \_\_\_\_\_

**Level of Work Effort:**

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

**Working in extreme temperature or humidity?:**



Yes \_\_\_\_\_

No

**Part II: To be completed by the physician or other health care provider (PHLCP) for respirator types indicated in Part I.**

<b>Name _____ of PHLCP:</b>		<b>Evaluation Date:</b>	
---------------------------------	--	-----------------------------	--

**Filtering Facepiece (N95, N100, P100)**

- Medically qualified to wear this type of respirator \_\_\_\_\_
- Medically qualified to wear this respirator with the following restrictions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Not Medically qualified to wear this type of respirator

**Powered Air Purifying Respirator**

- Medically qualified to wear this type of respirator \_\_\_\_\_
- Medically qualified to wear this respirator with the following restrictions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Not Medically qualified to wear this type of respirator

**Half Face Air Purifying Respirator**

- Medically qualified to wear this type of respirator \_\_\_\_\_
- Medically qualified to wear this respirator with the following restrictions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Not Medically qualified to wear this type of respirator

**PHLCP** \_\_\_\_\_ **Signature**  
\_\_\_\_\_

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

**Laguna Honda Hospital**

**FIT TEST CERTIFICATE**

**APPENDIX ED**

**FIT TEST CERTIFICATE**



## SECURITY MANAGEMENT PLAN

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients/residents served, staff, volunteers, contractors, and visitors.

### PURPOSE:

1. It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.
2. The objectives of the Security Management program include:
  - a. Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities;
  - b. Ensure timely and effective response to security emergencies;
  - c. Ensure effective responses to service requests;
  - d. Report and investigate security related incidents;
  - e. Promote security awareness and education;
  - f. Enforce various hospital rules and policies; and
  - g. Establish and implement critical program elements that safeguard people, equipment, supplies, medications, and control traffic in and around the hospital and the outlying buildings.

### SCOPE and APPLICATION:

1. The Security Management Plan comprises standards applicable to addressing and facilitating the protection, welfare, safety, and security of the environment. Included is a full range of protective services for persons, property, and assets at the hospital and outlying medical offices. The Security Management Plan requires compliance with all policies and procedures. The management plan calls for best in class

customer service for patients/residents, visitors, volunteers, contractors, and staff as well as the protection of property and assets.

2. The scope of the plan addresses program elements necessary to provide a safe and secure environment. Key aspects include:
  - a. Program planning, design, and implementation;
  - b. The measurement of outcomes and performance improvement;
  - c. Risk identification, analysis, and control;
  - d. Reporting and investigating of incidents, accidents, and failures;
  - e. Security Awareness, education, and training;
  - f. Emergency response;
  - g. Addressing legal and criminal matters;
  - h. Use and maintenance of equipment, locks, physical barriers, CCTV systems, alarms, etc.;
  - i. Security of medications;
  - j. Traffic control; and
  - k. Security of sensitive areas.

#### **AUTHORITY:**

The San Francisco Health Network (SFHN) provides the program's vision, leadership, and support. The Director of Health appoints a Director of Security who is responsible for the oversight of security program development, and implementation. The Director of Security reports to the Director of Health, and provides security consultation to the LHH Executive Administrator.

#### **PROCEDURE:**

1. Program Organization and Responsibilities
  - a. The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the contract security provider, San Francisco Sheriff's Department (SFSD) are responsible for the overall management of the security program. This includes the program design,

implementation, identification, control of risks, staff education, and training, and consultation.

- b. The Director of Security manages the security program across all divisions of Department of Public Health (DPH) and coordinates the implementation of the Memorandum of Understanding (MOU) with the San Francisco Sheriff's Department, ensuring that DPH staff are trained, follow established policies and procedures, comply with regulatory requirements, oversee and maintain security technology and equipment, track, analyze, and report on security incidents, and recommend improvements, review and share building plans for new construction and renovations for security issues such as accessibility, alarms, lighting and landscaping; ensures that annual security risk assessments are completed, and that appropriate resources are available to accomplish the objectives and goals of the security management plan. The Director of Security reports to the LHH Campus Safety and Security (CSS) Committee, and Executive Committee about the implementation of new procedures and operations, as well as installation of new systems.
- c. The SFSD Unit Commander manages the security, public safety, and law enforcement services at sites under DPH control, including providing security and law enforcement personnel, management of security and law enforcement operations, and compiles information from incident reports to form the quarterly reports that are submitted to the LHH CSS and Executive Committee. The Unit Commander assures that security and law enforcement staff receive hospital related training, participate in appropriate violence prevention, safety and security, and threat management committees; and assures that SFSD staff, assigned to LHH follow hospital security operation procedures.
- d. The Director of Security and the SFSD Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes, identify and troubleshoot emergent safety concerns, comply with hospital regulatory standards and requirements; meet service level agreements, resources and performance metrics; clearly define accountabilities and responsibilities; strategically and jointly address long-term and underlying safety conditions and solutions; provision of excellent customer service and professionalism from personnel providing security and law enforcement; and promote a culture of safety and security.
- e. The LHH CSS Committee is comprised of clinical, administrative, operations support services, and labor representatives who ensure that the security management program is aligned with the core values and goals of the organization by providing direction, set strategic goals, determine priority and assess the need for change. The LHH CSS Committee is the central hub of the Information Collection and Evaluation System and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and



integration of performance improvement, strategic planning and injury prevention activities in committee activities.

- f. In the context of security management, the LHH CSS Committee is designed to:
  - i. Develop strategic goals and annual performance targets, relative to Security and the Safety Program;
  - ii. Carry out analysis and seek timely, effective, and sustainable resolution to security related issues; and
  - iii. Prioritize goals and resources.
- g. Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established LHH CSS Committee programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of patients and their belongings.
- h. Employees are responsible for following security policies and practices for personal protection, reporting of security incidents, risks and threats. Employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices.

## 2. Risk Assessment

- a. Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing facility-wide processes that are coordinated by the Director of Quality Management, Chief Operations Officer, the Director of Security, and the contract security provider. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:
  - i. Routine Safety/Environmental of Care Rounds;
  - ii. \*Root Cause Analysis of significant events;
  - iii. \*Failure Mode and Effects Analysis (FMEA);
  - iv. \*Sentinel Event Alerts;
  - v. Security Patrols;
  - vi. \*Aggregated unusual occurrence reports - Review of pertinent data/information, incident reports, evaluations and risk assessments;

- vii. Community crime statistical data or CAPRISK Reports;
- viii. Facility crime, incident and property loss statistics (\*UO and SFSD Crime stats)- including workplace violence statistics;
- ix. Customer and benchmarking surveys;
- x. \*At Risk patients/residents (such as clinically indicated restraints, medical holds, and stand-by services);
- xi. Hours of operation;
- xii. Employee, resident and visitor identification; and
- xiii. Hospital and Rehabilitation Center operations and processes

Note: Considerations marked with an asterisk (\*) may be subject to California Evidence Code Section 1157 confidentiality provisions and may not be discussed publicly.

- b. The profile of potential risks results in an integrated approach to risk control and management. Identified "Sensitive Areas" include the areas where Protected Health Information (PHI) are kept, Administrative Offices, Human Resources, Pharmacy, Nutritional Services, and Psychiatry.

### 3. Program Implementation and Process

- a. Successful implementation of the Security Management Plan involves the incorporation of the principles of the plan into the culture and operations of the organization. Implementation of the security program is the responsibility of the Director of Security, and SFSD Unit Commander. The performance is monitored quarterly by the LHH CSS Committee and the Executive Committee. They include:
  - i. The designation of a person to be responsible for program development and oversight. The Health Director has designated the Director of Security as the person responsible for the quality oversight of the security program's development, implementation and monitoring.
  - ii. The Security Services Department and the San Francisco Sheriff's Department conduct investigations and completes written reports about security incidents involving patients, staff, visitors, volunteers, and property. Investigations are documented and reviewed by the SFSD Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with

- the SFSD Unit Commander ensures that incident reports are distributed to the appropriate departments (i.e. Quality, Risk Management, etc.) Significant events are reported to the Executive Administrator, and the Administrator-on-Duty and to the Director of Workplace Safety and Emergency Management.
- iii. Security will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, consultant physicians, volunteers, and vendors.
  - iv. Access to the hospital's perimeter and buildings are maintained by a lock down of unoccupied areas, routine checks on all perimeter doors, and securing of individual departments after normal business hours. The contract security provider ensures that access to the facility is restricted by confirming unauthorized personnel and escorting them off the premises.
  - v. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.
  - vi. The contract security provider conducts regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital grounds. Regular patrols and security checks of stairwells, campus interior and exterior, and parking areas are conducted to deter theft, vandalism and other criminal activity. Security and Law Enforcement presence includes foot patrols, vehicle patrols and recording of CCTV cameras in the Security Operations Center and maintaining fixed positions.
  - vii. The Director of Security is actively involved in a multidisciplinary, hospital wide Threat Management Team, and provides both investigative and protective services. The Director of Security in collaboration with the SFSD work closely with Administration, Human Resources, the Department of Public Health, and other law enforcement agencies on matters concerning criminal cases, threat management investigations, and other non-criminal cases.
  - viii. The Security Operations Center monitor all alarms, radio, and security telephone transmissions to ensure that the appropriate actions are initiated and communicated.
  - ix. The Security Services Department, and SFSD maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, patients, and environmental issues will be forwarded to the Safety Manager and the Risk Manager.

- x. The Security and Facility Services Departments maintain and coordinate the card access program. The requestor submits an Access Card Request form signed by the requestor's manager. The Access Card Request form is reviewed by the Facility Services Department to determine the need for the requestor to have card access. Approved Card Requests are processed by Facility Services. Records of all issued access cards are maintained with Human Resources and Facility Services.
- xi. The SFSD provides emergency response upon notification for the following:
- Code Blue – provide crowd control as needed.
  - Code Red – respond to the alarm point of origin to assist in implementing the initial fire safety plan, provide assistance to local fire department and Facility Services.
  - Code Yellow (internal / external disasters) - provide staff to control access to the facility and provide assistance to/from local emergency response agencies.
  - Code Green - deploy security personnel to designated locations to establish a perimeter and begin the search for the missing patient.
  - Code Silver – deploy security personnel to neutralize the threat of an active shooter.
  - Dr. Grey – deploy security personnel to the alert point of origin to provide assistance in responding to the threat.
  - Manage situations involving media or VIPs by providing assistance to the Information Office and/or Administration and safeguarding info on any VIP on premises.
  - Lockdown Procedure - Heightening existing security measures as needed during civil unrest, disturbances, or acts of terrorism.
  - Security also provides emergency assistance to medical/clinical staff, including but not limited to stand-by services, patient restraints, searching for missing persons, crowd control, response to duress alarms, etc.
- xii. All new employees, at the time of hire, will attend a New Employee Orientation Program. All employees will receive basic information related to the Security Services Department and its Security Management Plan. During the security portion of the orientation, employees will receive information about the following:

- A description of the Security Services Department
  - Security services provided
  - Prudent security practices
  - ID Policy
  - Unusual Occurrence (UO) System
  - Stairwell Security
  - Reporting a security incidents or suspicious activity
  - Security locations and phone numbers, etc.
- xiii. Additional training will be administered as needed to assure competency in federal, state, local laws, and regulations: Crisis Prevention and Intervention, SMART, Management of Aggressive Behavior and Workplace Violence response.
- xiv. The SFSD Unit Commander will verify that each SFSD employee assigned to Laguna Honda Hospital and Rehabilitation Center complete the required New Employee Orientation Training, six week Healthcare Security Training, and core competencies with respect to security emergencies.
- xv. Documentation will be retained by the Department of Education and Training and/or the SFSD Training Coordinator. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements and/or findings of the Safety and Emergency Management Committees.

#### 4. Program Effectiveness

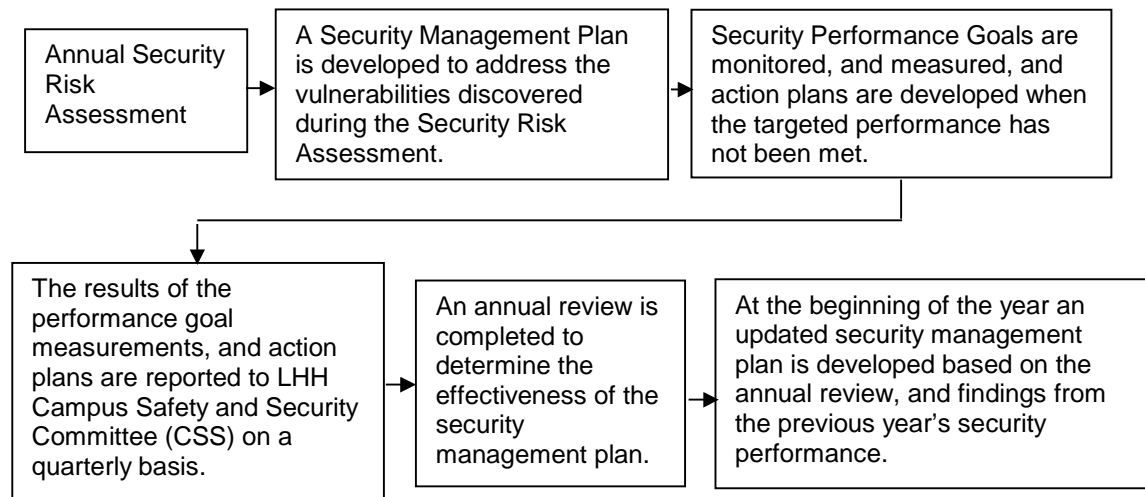
- a. Through the LHH CSS Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance measures to create a safe and secure environment for staff, patients and visitors to the hospital. Performance is reported to the LHH CSS and Executive Committee on a quarterly basis. Recommendations are made as needed to facilitate improvements in performance. Action plans are developed and implemented as needed to improve performance.

#### 5. Annual Program Evaluation

- a. On an annual basis, the security management program is evaluated and assessed relative to its objectives, scope, security risks, vulnerabilities,

effectiveness and performance. This evaluation process is coordinated through the Director of Security, in conjunction with the contract security provider, LHH CSS Committee, and the Executive Committee. The continued appropriateness and relevance of program objectives are assessed, as well as whether or not these objectives were met. The scope is evaluated to determine continued applicability. The year is reviewed retrospectively to determine the extent to which the program was effective in meeting the needs of the hospital, the residents and staff. The performance results are assessed as an indicator of ongoing performance improvement. Results of this evaluation process will form the basis for strategic goal setting, planning, and verifying the continued applicability of program objectives. The annual security assessment report is submitted for review to the LHH CSS Committee, Hospital Executive Committee, Performance Improvement and Patient Safety Committee and to the Joint Conference Committee for approval.

b. Security Management Plan Process:



**ATTACHMENT:**

None.

**REFERENCE:**

California Code of Regulations, Title 8, Sections 8 CCR 3203 *et seq.*

California Code of Regulations, Title 22, Sections 22 CCR 70738

Health & Safety Code, Section 1257.1, 1257.8, 1257.7

[California Penal Code](#)

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 16/03/08 (~~Year, Month, Day~~)

## SECURITY SERVICES STANDARD OPERATING PROCEDURES

### POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) takes reasonable preventive measures to provide a safe environment for everyone on LHH premises. LHH has zero tolerance toward violence, threats/intimidation that involve, or affect LHH or occur on LHH premises. As such, the possession of weapons on LHH premises is strictly prohibited. Anyone engaging in conduct that violates this policy is subject to remedial action.

### PURPOSE:

The purpose of this policy is to: safeguard all covered persons, patients, and visitors, volunteers, and Department of Public Health (DPH) employees located at LHH, by addressing threats and aggressive behavior at the earliest stage; define inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

To provide guidelines for handling and responding to security related incidents. The Standard Operating Procedures (SOP) elaborate on existing hospital policies, and define the processes, and expectations of security services performed by the contract suppliers of security, public safety, and law enforcement services, hereafter referred to as the contract security provider.

### SCOPE:

This policy applies to all employees, contractors, students, and volunteers ("covered persons") who are employed by or provide services to Laguna Honda Hospital and Rehabilitation Center.

The SOPs found herein do not supersede existing hospital policies and procedures, but are to be utilized as a reference in the carrying out of security services. The contract security provider will develop, and maintain their own operation procedures, which will align with LHH Security SOPs.

### DEFINITION:

**Acts/Threats of Violence** – Any actions, statements or other intimidating conduct that gives reasonable cause to believe that the personal safety of an individual or group of individuals may be at risk.

**LHH Premises** – Any building or space, including parking lots, owned, leased, or operated by Laguna Honda Hospital and Rehabilitation Center, or a subsidiary.

**Remedial Action** – Includes, but is not limited to, corrective action/discipline up to and including termination of employment, criminal/civil prosecution if the conduct involves a violation of law.

**Weapon** – Includes any instrument, article, object, or substance which, under the circumstances, could reasonably be used to cause physical injury or death, such as firearms, knives, clubs, stun guns, or incendiary devices.

## **PROCEDURE:**

### **1. Security Operations Center (refer to appendix Q for further details)**

- a. The Security Operations Center (SOC) will operate as the dispatch and security call center for the all security related incidents occurring at LHH campus and premises.
- b. The contract security provider will ensure that the SOC is staffed with professionally trained dispatchers and telephone operators.
  - i. The SOC is responsible for supporting the Incident Command Center during any activation of the emergency and disaster response plan.
  - ii. The SOC operator must be able to initiate the plan of action for all information coming into the operations center via surveillance cameras, alarm panels, duress buttons, resident locator mobile view, emergency phones, and phone lines.
  - iii. The dispatcher's ultimate goal is to provide timely security and law enforcement service to Laguna Honda's customers. Assigned security provider staff will be trained, and demonstrate a working knowledge of all SOC and Security Response Procedures.
  - iv. The SOC is under the direct supervision of the contract security provider's leadership.
  - v. The SOC is responsible for the following tasks:
    - Monitor, acknowledge, and respond to all alarms coming into the SOC.
    - Monitor CCTV cameras of all high risk areas, and dispatch contract security provider personnel to address all suspicious persons and activity.
    - Dispatch security personnel to all security related incidents.
    - Coordinate security responses to all security emergencies.



- Perform additional security related task as directed by the contract security provider's leadership.
- Document all service calls.
- Notify all necessary parties of emergency situations.
- Record all emergency and non-emergency service calls coming into the SOC i.e. names, locations, times, activities, and length of service time.
- Participate in monthly electronic system inspections.
- Maintain SOC equipment and systems, and report system malfunctions, and track repair status.
- Report procedural discrepancies to appropriate parties.
- Participate in preliminary and continuing investigations, including providing security records in accordance with the Records Retention, and Disclosure Policy (refer to LHHPP 75-15 Security Records Retention and Disclosure Policy).

## 2. Identification of employees, patients and visitors

- a. All LHH employees, patients and visitors shall have identification when on LHH premises.
- b. All visitors authorized to enter the hospital will be issued a visitor's pass by the contract security provider.

### 4.3. Reporting

- a. Covered Persons are required to report any acts or threats of violence when they have observed or otherwise learned of such conduct by any person working for LHH, on LHH premises, using LHH services or that could reasonably be believed to affect the LHH workplace.
- b. Patients or visitors to LHH premises are encouraged to make reports when they have observed or otherwise learned of conduct prohibited by this policy. LHH will encourage such reporting and will assist in the process.
- c. Incidents shall be reported to the Department Manager and Director of Security immediately. The contract security provider shall be called first for incidents that pose imminent danger of physical harm.

- d. Retaliation against anyone who reports acts or threats of violence, or who participates in any procedures or investigations related to such complaints will not be tolerated.
- e. All reports will be evaluated promptly, and remedial action will be taken when appropriate.
- f. All employees who obtain a protective or restraining order which lists any LHH premises as protected areas shall provide a copy of the order to the contract security provider, Director of Security, and their Human Resources representative.

#### **2.4. Prohibition of Weapons**

- a. The use or brandishing of any weapon to threaten or assault anyone on LHH premises is prohibited. Unless permitted by law and authorized in writing by the Director of Security in consultation with the Department of Public Health (DPH) director, hospital administrator or designee, employees may not have firearms in their vehicles if they park on LHH premises. The only exceptions to this prohibition are:
  - i. Local, state, and federal law enforcement personnel who are required by their agencies to carry weapons may bring them into LHH facilities.
  - b. As required during any regulatory investigation or as requested by Administrative staff, the contract security provider may be required to produce copies of their operation procedures, training documents, hospital training related to proficiency in core competencies, or participate in interviews pertaining to their services performed at LHH.

#### **3.5. Searches**

- a. LHH reserves the right to have authorized personnel conduct searches (e.g. of workspace, company-owned vehicles, clothing, packages, purses, backpacks, etc.) of employees or patients that authorized personnel reasonably believe may be carrying a weapon into LHH premises in violation of this policy.
- b. Any recommendations for change, additions, clarifications or deletions to these Standard Operating Procedures shall follow LHH's policy on procedures.

#### **4.6. Threat Management Plan**

- a. The Director of Security is responsible for ensuring that all LHH premises are covered by a Threat Management Plan.
- b. The Security Services Department in collaboration with Hospital Administration is responsible for developing a Threat Management Plan and designating a core

group of individuals responsible for Plan implementation in response to any reports or actions by covered persons, patients, or visitors who are or may be in violation of this policy.

c. The contract security provider shall follow the Department of Public Health's policies on privacy that includes the following:

i. Authorization for Use and Disclosure of Protected Health Information

ii. Data Security Policies

iii. DPH Privacy Policy

iv. Recording at DPH Facilities

**5.7. DPH, City and County, and LHH Resources**

- a. The Director of Security in collaboration with the contract security provider provides specialized personnel protection services and specialized investigations.
- b. City attorneys advise managers on legal issues and initiate and manage any legal services which may be required (e.g. restraining orders, injunctions).
- c. Hospital Administration and the Communication's Department will develop and execute strategies, and publicize these through internal and external communications.
- d. DPH Human Resources and Labor Relations assists with questions involving the application of human resources policies, and/or collective bargaining agreement interpretations.
- e. Employee Assistance Program (EAP), and the Staff Incident Response Team (SIRT) serves as a resource to Threat Management Team to determine support services needed for covered persons, patients, or visitors affected by threats or acts of violence that have occurred on LHH premises or that could reasonably be believed to affect the LHH workplace. Support services may include, but are not limited to:
  - i. Clinical assessment of the individual deemed to be potentially violent.
  - ii. Assess the level of acuity related to the threat/act of violence.
  - iii. Coordination of critical incident management services.
  - iv. Referral to appropriate clinical behavioral services.

- v. Referral to appropriate community services.
- f. DPH, City and County, and LHH resources may also include the coordination of outside consultants for threat assessment and case management support as appropriate.

#### **6-8. Media Relations**

- a. The DPH Director of Communications will consult with the hospital's Executive Administrator/designee, Director of Security, and others as appropriate, prior to sharing information with reporters or other external audiences.

#### **ATTACHMENT:**

Appendix A: Threats and Violence in the Workplace: Prevention and Management Guidelines

Appendix B: Reporting Details for Threats or Acts of Violence

Appendix C: Threat Management Incident Flow Chart

Appendix D: Threat Management Grid

Appendix E: Threat Management Response Grid

Appendix F: Patrol Procedures

Appendix G: Security Incident Report Writing and Investigations

Appendix H: Visitors Screening Process

Appendix I: Arrest Procedure

Appendix J: Laguna Honda Hospital and Rehabilitation Center Security Training Program

Appendix K: Enforcement of the Smoking Policy

Appendix L: Response to Internal and External Emergency Disasters

Appendix M: Security Service Department Job Descriptions

Appendix N: Identification of Employee, Patients/Residents and Volunteers

Appendix O: Personal Safety and Cash Escorts

Appendix P: Security Operations Center

Appendix Q: Security Response Call Procedures

Appendix R: Significant Security Event Notification

Appendix S: Victims of Violent Crime Protection Plan

#### **REFERENCE:**

~~None.~~

LHHPP 01-03 Hospital Organization Chart

LHHPP 24-07 Visiting Hours

LHPP 24-22 Code Green Protocol

LHPP 70-04 Code Silver

LHPP 70-05 Resident Evacuation Plan

LHPP 70-06 Fire Response Plan

LHPP 70-07 Spill Response Plan

LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan

LHHPP 76-02 Smoke and Tobacco Free Environment

File: 75-10 Security Services Standard Operating Procedures ~~New March 8, 2016~~ Revised July 12, 2016

[DPH Organizational Chart – www.sfdph.org](http://www.sfdph.org)

[California Penal Code](#)

[SFSD 520.217 San Francisco Sheriff's Department Form: Arrest by Private Person](#)

Revised: 16/07/12 (Year/Month/Day)

Original adoption: 16/03/08 (~~Year, Month, Day~~)

## **Appendix A: Threats and Violence in the Workplace: Prevention and Management Guidelines**

These guidelines support the LHH *Workplace Violence Prevention Program*. The guidelines are a tool to assist the Threat Management Team and hospital staff responsible for threat management. The guidelines include:

- An overview of what to include in a threat management plan
- Suggested roles and responsibilities of the threat management team
- Guidelines for threat reporting, investigation, assessment and response
- Criteria for monitoring, evaluation and closure of incidents
- Threat documentation retention requirements
- Incident reporting format
- A threat management flow chart
- Risk assessment and response grids

### **1.0 Elements of a Threat Management Plan**

- 1.1 Designation of a core group of individuals who are responsible for developing and implementing the Threat Management Plan.
- 1.2 Creation of protocols for appropriate follow-up/action plan to actual acts/threats of violence which shall include the following elements:
  - 1.2.1 Designation of appropriate levels of authority for decision making.
  - 1.2.2 Prompt, thorough, factual, and coordinated investigation of reports made.
  - 1.2.3 Privacy and confidentiality issues shall be given utmost consideration. Information about the triggering incident and investigation shall be strictly limited to those persons who have a need to know, to include those individuals administering the Threat Management Plan, potential identifiable victims of the threat, city police, the contract security provider, and administrative staff. Distribution of investigation reports or information shall be appropriately limited.
  - 1.2.4 Assessment of the risk utilizing risk assessment and investigation tools.
  - 1.2.5 Coordination with DPH, City and County, and LHH resources, as appropriate.

- 1.2.6 Timely and appropriate response for varied situations (e.g. critical incident stress debriefing or debriefing of affected staff).
- 1.2.7 Appropriate provision of benefits and support services for victims and witnesses (may include confidential counseling, security, or other support services).
- 1.2.8 Security and safety assessment, if required by relevant state law and regulation, including an assessment of trends of aggressive and violent behavior and required training for staff, periodic re-evaluation of physical security applications (e.g., access control procedures, camera installation, alarms or distress buttons), and the establishment of a viable security management plan that ensures a sustained level of security preparedness in vulnerable areas such as Emergency Departments. (For California plans refer to California Occupational Health and Safety Act and California Health and Safety Code 1257.7 and 1257.8 (Hospital Security Act).
- 1.2.9 Worksite analysis to identify and correct hidden hazards or unsafe conditions (e.g. unlighted areas or areas where access shall be restricted because of the probability of violence).
- 1.2.10 Consistency with DPH and LHH policies on related issues, transfer laws regarding psychiatric patients, and employer protocol for appropriate disciplinary action, up to and including termination of employment.

### 1.3 Staff training and intervention procedures.

## 2.0 Composition and Responsibilities of Threat Management Team

- 2.1 The Threat Management Team shall embody a multi-disciplinary perspective, including representatives of front line management, Risk Management, LHH Administration, DPH Security Services, Human Resources, Psychiatry Department, and Legal. In a situation involving a patient or visitor, the Team shall include clinical leadership/providers, and legal who will assist with patient/visitor issues, determinations, and communications. The DPH Communication Officer will be contacted for any incidents that may attract media attention. The Team will not include anyone who is personally involved in the specific situation or who is a target of the act or threat of violence.
- 2.2 The Team will designate a clearly identified leader. The Team leader is responsible for:
  - 2.2.1 Assembling the team members and ensuring appropriate representation discussed above.

2.2.2 Identifying and assigning tasks to implement a Threat Management Plan.

2.2.3 Adjourning the team meetings, developing the meeting agendas, and making certain meeting minutes are recorded and retained.

2.2.4 The Team is responsible for implementation of the elements required of a Threat Management plan (see Section 1.0).

2.2.5 The Team shall meet regularly and retain minutes of meetings, consistent with LHH records retention guidelines.

2.2.6 The Team shall regularly analyze trends/patterns to revise/update preventive measures.

### **3.0 Reporting**

3.1 The contract security provider will be called if there is immediate danger to any persons, i.e., perpetrator has a firearm drawn and poses an immediate threat.

3.2 The DPH Director of Security will be specifically identified as the person to whom incidents of violence shall be reported.

3.3 Reports of threats or violence shall be specific and detailed.

3.4 Unusual Occurrence Security Incident Reports can be used or adapted to document threats. Reports shall, at a minimum include the following:

3.4.1 A detailed description of the incident using specific language and quotes where possible

3.4.2 When and where it occurred

3.4.3 Identity and contact information of all involved parties (aggressor/target/witnesses)

3.4.4 Identity and contact information of manager/supervisor of both aggressor and target.

3.5 Managers shall engage with the Threat Management Team to determine who is responsible for Investigation and Risk Assessment.

### **4.0 Investigation and Risk Assessment**

4.1 Investigations shall be prompt, thorough, and well documented. HR will be included in any investigations involving employee threats. Represented employees are entitled to have union representation if they are involved in an



investigation.

**4.2** Risk is assessed based upon all relevant information available and after consultation with experts where appropriate. A risk level shall be assigned based on the following criteria:

**4.2.1** Low Risk: This rating is consistent with a situation that requires management or security intervention, but where there is little reason to believe the individual's behavior will escalate to a higher level of aggression, where heightened emotion is successfully defused.

**4.2.2** Moderate Risk: This rating is consistent with a situation that requires management and security intervention and where there is reason to believe the individual's behavior will escalate to a higher level of aggression or violence without specific remedial action.

**4.2.3** High Risk: This rating is consistent with a situation that requires management and security (and possibly law enforcement) intervention and where there is evidence to support a high probability of imminent danger of injury or death to one or more individuals.

**4.3** The Assessment Grid is a tool to assist in the assessment of risk but shall not be relied upon exclusively.

## **5.0 Response**

**5.1** The appropriateness and scope of the response to an act or threat of violence is determined on a case-by-case basis, based on the assessed risk level. The appropriate response for the Threat Management Team varies depending on the assessed risk level.

**5.2** The identification and use of internal and external resources also varies based on the assessed risk level:

**5.3.1** Low Risk: A manager may handle and resolve a low risk incident of threat or act of violence without intervention of the Threat Management Team. The manager shall forward a copy of the initial report and a written summary of the assessed level of risk and action taken to the appropriate Threat Management Team member within 24 hours of resolution.

**5.3.2** Moderate Risk: A moderate risk incident of threat or act of violence shall be referred to the Threat Management Team. The Threat Management Team may at its discretion, consult with DPH, City and County resources, or LHH executive leadership for input regarding the appropriate response.

5.3.3 High Risk: A high risk incident of threat or act of violence shall be assessed and managed mutually by the Threat Management Team. This coordination will ensure specialized resources are appropriately factored into the resolution process.

5.4 The agreed upon response shall be documented in a detailed and specific action plan with next steps clearly identified and assigned to appropriate individuals.

## 6.0 Monitoring, Evaluation and Closure

6.1 For low risk incidents of threats or acts of violence, Management is responsible for monitoring the success of the action plan and making adjustments when necessary.

6.2 For moderate and high risk incidents of threats or acts of violence, a designated member of the Threat Management Team will monitor the success of the action plan and will convene the Team as needed if adjustments are necessary.

6.3 The Threat Management Team will periodically review inactive matters to identify trends and best practices.

## 7.0 Documentation/Retention

7.1 Documentation of incidents involving employee violence will be retained by the Human Resources Department. Incidents involving patients/residents will be maintained in the Patient Advocate Department. DPH Security investigations will be maintained with the DPH Director of Security. Incidents documented by the contract security provider will be handled in accordance with their operating procedures.

7.2 Threat Management Team meeting minutes and issue logs, tracking status/logs and resolution of reported issues will be retained by the Team.

## **Appendix B: Reporting Details for Threats or Acts of Violence**

### **1.0 Reporting Responsibilities for Threats or Acts of Violence**

Reports of threats or acts of violence may be reported by any employee, physician, resident, contractor, student, or volunteer who is the victim of, or witness to, a threat or act of violence. Residents, or visitors to LHH premises may also make reports when similar circumstances apply. Reports shall be submitted for such acts on LHH premises or when an act is reasonably considered to have an impact on the workplace.

### **2.0 Types of Threats or Acts of Violence Reported**

Reports may include any acts or threats of violence including physical assaults and actions or statements, words, gestures, symbols, intimidation, or coercion that reasonably causes the affected individual or others, to believe their personal safety may be at risk. Examples include, but are not limited to:

#### Direct threats

Profanity or abusive language  
Yelling  
Stalking  
Harassment including repeated phone calls  
Intimidation

#### Indirect or vague threats

Physical aggression or assaults  
Altercations  
Written or verbal threats  
Aggressive acts

### **3.0 Report Details**

Incident reports shall include all relevant objective facts and details of the threat or act of violence that occurred. Reports shall not include opinions or subjective perspectives of the incident. Reports shall include:

- What happened
- Where it happened
- Who was involved
- What was said
- Names of others who observed the incident
- Name of person threatened
- Name of person making threat

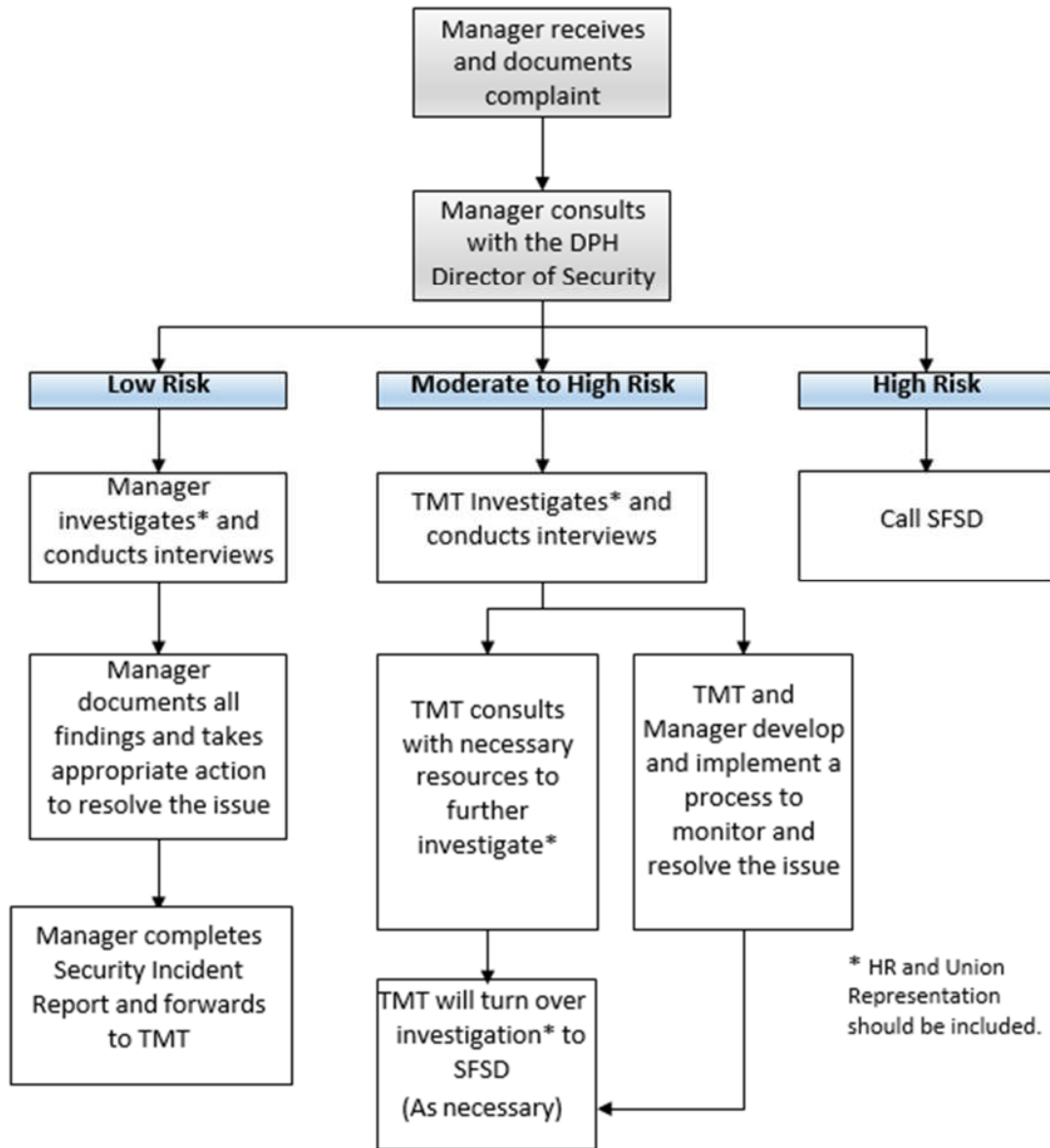
### **4.0 Report Submission**

Incident reports shall be submitted as soon as possible, and not later than 24 hours after the incident. Reports shall be completed by the manager or supervisor of the victim of a threat or act of violence. If a manager or supervisor is not available, reports shall be taken by any other manager, supervisor, administrator, Human Resources representative, or security personnel.

## 5.0 Next Steps

The Threat Management Team shall consult with the manager or supervisor who submitted the incident report and assess the risk. If the risk is determined to be a low level risk, the manager shall be directed to interview witnesses. The Threat Management shall designate an investigator for moderate and high risk situations. The investigator will complete an incident report, and forward it to the Threat Management Team. The Threat Management Team will work with the manager to develop, implement, and monitor a plan of action to address, and resolve the problem.

### Appendix C: Threat Management Incident Flow Chart



## Appendix D: Threat Management Assessment Grid

The following Assessment Grid is to serve as guidelines to assist the Threat Management Team in developing an action plan to address a threat/workplace violence incident.

Assessment Grid			
	Low Risk	Moderate Risk	High Risk
<b>Escalating Aggression</b>	<ul style="list-style-type: none"> <li>One or two indirect threats or intimidating actions.</li> <li>Intimidating style, at least occasionally</li> <li>One or two angry outbursts/hostile style</li> <li>One or two incidents of perceived harassment</li> <li>Unacceptable physical actions short of body contact or property damage (e.g. door slamming, throwing small objects)</li> </ul>	<ul style="list-style-type: none"> <li>Two or more threats with increasing specificity</li> <li>Conscious intimidation or repeated bullying; impulsive</li> <li>Repeated angry outbursts/overt angry style, inappropriate to context</li> <li>Repeated pattern of harassment</li> <li>Intentional bumping or restricting movement of another person</li> </ul>	<ul style="list-style-type: none"> <li>Clear, direct, multiple threats; ultimatums-especially to authority; evidence of a violent plan</li> <li>Intense undissipated anger</li> <li>Repeated fear-inducing boundary crossing or seeking direct contact; stalking; violating physical security protocols with malicious intent</li> <li>Grabbing, grappling, striking, hitting, slapping, or clearly using harmful force</li> </ul>
<b>Weapons Involvement</b>	<ul style="list-style-type: none"> <li>Firearm in home</li> <li>Long term, sanctioned use (e.g. hunting, target shooting, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Firearm in vehicle</li> <li>Increased training without known reason (e.g., not hunting season, competition approaching, etc.)</li> <li>Emotionally stimulated by the use of a weapon for any purpose</li> <li>Acquire new weapons or improve weapon(s)</li> <li>Inappropriate display not directed toward others</li> </ul>	<ul style="list-style-type: none"> <li>Carries firearm on person outside of home</li> <li>Escalated practice or training in association with emotional release or issue preoccupation</li> <li>Intense preoccupation with or repeated comments on violent use of weapons</li> <li>Use or display of any weapon to intimidate harm</li> </ul>
<b>Negative Mental Status</b>	<ul style="list-style-type: none"> <li>Tendencies toward depression, agitation or "hyper" behavior</li> <li>Tendencies toward suspiciousness, blaming others, jealousy or defensiveness</li> <li>Low/moderate substance use without links to violence related behaviors</li> <li>Anger, some felt entitlement, or humiliation over any negative employment action or relationship setback</li> </ul>	<ul style="list-style-type: none"> <li>Depressed, mood swings, "hyper", or agitated</li> <li>Paranoid thinking, bizarre views, defensiveness, blaming others, hostile attitude; hostile jealousy</li> <li>Substance abuse, especially amphetamine, cocaine, or alcohol</li> <li>Unremorseful but compliant to avoid punishment (e.g. jail)</li> <li>Mental preoccupation, persistent anger, entitlement, or humiliation over any negative employment action or relationship setback</li> </ul>	<ul style="list-style-type: none"> <li>Depression unrelenting or with notable anger, high agitation or wide mood swings</li> <li>High paranoia; homicidal/suicidal thought; psychotic violent thoughts</li> <li>Substance abuse drives or exacerbates aggression/violence, or verified amphetamine or cocaine dependence</li> <li>Obsession &amp; strong feelings of anger, injustice, or humiliation over any negative employment action or relationship setback; feels desperate, trapped</li> </ul>
<b>Negative Employment Status</b>	<ul style="list-style-type: none"> <li>Possible discipline, negative performance review or termination non-violence related</li> <li>Bypassed for raise, promotion, recognition or opportunity</li> </ul>	<ul style="list-style-type: none"> <li>Recent/pending disciplinary action or negative review</li> <li>Probable/pending termination or demotion, reinstatement unlikely</li> <li>Unstable employment in last year</li> </ul>	<ul style="list-style-type: none"> <li>Separation/termination inevitable</li> <li>Terminated &amp; all legal &amp; other resources for reinstatement or compensation exhausted &amp; ruled against subject</li> </ul>

<b>Assessment Grid</b>			
	<b>Low Risk</b>	<b>Moderate Risk</b>	<b>High Risk</b>
<b>Personal Stressors</b>	<ul style="list-style-type: none"> <li>● Mild disruption in primary intimate relationship</li> <li>● Mild financial problems</li> <li>● Minor legal issues</li> <li>● Minor health problems</li> <li>● Inconsistent support system</li> </ul>	<ul style="list-style-type: none"> <li>● Primary relationship disruption (birth, separation, betrayal)</li> <li>● Significant financial pressures – to increase with job loss</li> <li>● Legal problems</li> <li>● Demoralizing health problems</li> <li>● No or marginal support system</li> <li>● Negative coping style</li> </ul>	<ul style="list-style-type: none"> <li>● Recent relationship loss (death, divorce, betrayal, abandonment)</li> <li>● Serious financial crisis</li> <li>● Serious legal problems</li> <li>● Serious health problems</li> <li>● No support system</li> <li>● Destructive coping style</li> <li>● Target of high provocation by associates or intimates</li> </ul>
<b>History of Violence and Conflict</b>	<ul style="list-style-type: none"> <li>● Early life problems at home/school</li> <li>● Pattern of mildly conflictual work relationships in past</li> <li>● Behavior related job turnovers</li> </ul>	<ul style="list-style-type: none"> <li>● Victim or witness to family violence as child or adolescent</li> <li>● History/pattern of litigiousness</li> <li>● Arrests/convictions, non-violence</li> <li>● History of serious work conflicts</li> </ul>	<ul style="list-style-type: none"> <li>● Has violated protective orders</li> <li>● Arrests/convictions for violence</li> <li>● Credible evidence of violent history</li> <li>● Failed parole/probation programs</li> <li>● Highly isolated; "loner" style</li> </ul>
<b>Buffers</b>	<ul style="list-style-type: none"> <li>● Evidence of respect or restraint shown</li> <li>● Responded favorably to limit setting, especially recently</li> <li>● Wants to avoid negative consequences for threatening behavior (e.g. jail, legal actions)</li> <li>● Genuine remorse for scaring people</li> <li>● Genuine understanding that violence or threats is not an acceptable course of action</li> <li>● Lack of inappropriate emotional associations or attachment to weapons</li> <li>● Appropriate seeking of legal help or other guidance with issue</li> <li>● Wants to genuinely negotiate or appropriately resolve differences</li> <li>● Job/relationship not essential to self-worth or survival strategy</li> <li>● Engages in planning for future</li> <li>● Adequate coping responses</li> <li>● Positive family/personal relationships; good support system</li> <li>● Religious beliefs prohibit violence, provide solace</li> <li>● No financial health or legal problems</li> </ul>		
<b>Organizational Influence &amp; Impact</b>	<ul style="list-style-type: none"> <li>● Employee(s) fear of violence</li> <li>● Supervisory/management personal fear of violence</li> <li>● Highly vulnerable specific target(s) of serious harassment/stalking/predatory searching</li> <li>● Fear-induced employee(s) performance disruption, job avoidance/absenteeism</li> <li>● Heavy workload, high stress environment</li> <li>● Generally adversarial conflictual/mistrustful work environment</li> <li>● Counterproductive employee attempts to intervene/prevent violence</li> <li>● Co-worker or supervisor provocation of subject</li> <li>● Co-worker (or others) support of or encouragement of violent course of action</li> <li>● Management lack of knowledge of workplace violence dynamics or warning signs</li> <li>● Management denial or minimization of potential seriousness of situation</li> <li>● Management lack of crisis management experience/skills/tolerance level</li> <li>● Management active negative case management responses</li> <li>● Management resistance to accepting appropriate/specialized assistance</li> <li>● Management unavailability/remoteness from location of situation/key individuals</li> </ul>		

## Appendix E: Threat Management Response Grid

The following Response Grid is to serve as guidelines to assist Threat Management Team in developing an action plan to address a threat/workplace violence incident.

Response Grid			
	Low Risk	Moderate Risk	High Risk
<b>Assessment</b>	<ol style="list-style-type: none"> <li>Employer representative initial data intake</li> <li>Employer informant interviews</li> <li>Employment related file review, if applicable</li> <li>Consider violence risk assessment specialist phone review with Core TMT</li> <li>Management "reality check" meeting with subject of concern</li> </ol>	<ol style="list-style-type: none"> <li>Employer representative initial data intake</li> <li>Employer informant interviews</li> <li>Employment related file review, if applicable</li> <li>Violence risk assessment specialist phone or on-site consultation with Core or full TMT</li> <li>Management "reality check" meeting with subject of concern</li> <li>Violence risk assessment specialist on-site interviews with target(s) and informant(s)</li> <li>Formal violence risk evaluation (off-site) or on-site evaluation by violence risk-assessment professional/team</li> </ol>	<ol style="list-style-type: none"> <li>Employer representative initial data intake</li> <li>Employer informant interviews</li> <li>Employment related file reviewer, if applicable</li> <li>Violence risk assessment specialist phone and on-site consultation with full TMT.</li> <li>Violence risk assessment specialist on-site interviews with target(s) and informant(s)</li> <li>On-site evaluation by violence risk assessment professional/team</li> <li>Post on-site evaluation for involuntary hospitalization</li> </ol>
<b>Security</b>	<ol style="list-style-type: none"> <li>Cursory background investigation-recent, local criminal/civil history</li> </ol>	<ol style="list-style-type: none"> <li>Full background investigation</li> <li>Law enforcement liaison</li> <li>Security plan for interviews with management, informants, and subject</li> <li>Security plan for interviews with non-employee subject.</li> </ol>	<ol style="list-style-type: none"> <li>Full background investigation</li> <li>Law enforcement liaison</li> <li>Full security plan for interviews, perimeter protection &amp; reaction teams</li> <li>Consider target relocation</li> <li>Security plan for termination.</li> <li>Security for TRO service</li> <li>Target education on personal security &amp; possible legal actions</li> </ol>
<b>Legal</b>	<ol style="list-style-type: none"> <li>Legal consultation or incident management strategies, including communications strategy to maintain privilege &amp; control and direction of cursory background investigation</li> </ol>	<ol style="list-style-type: none"> <li>Legal consultation on incident management strategies, including communications strategy to maintain privilege &amp; control and direction of full background investigation</li> <li>Consider civil or criminal legal action</li> </ol>	<ol style="list-style-type: none"> <li>Legal consultation on incident management strategies, including communications strategy to maintain privilege &amp; control and direction of full background investigation</li> <li>Management of restraining order process</li> <li>Consider civil or criminal legal action</li> </ol>
<b>Human Resources Actions</b>	<ol style="list-style-type: none"> <li>Post assessment employment action/counseling</li> <li>Referral for treatment (suggested vs. required)</li> <li>Post action constituency and communication</li> <li>Audit of employment related issues and actions including Title VII, privacy, harassment, etc.</li> </ol>	<ol style="list-style-type: none"> <li>Management meeting with subject to inform of status and requirement for evaluation</li> <li>Possible post fitness for duty referrals for treatment</li> <li>Post action consultancy communication &amp; debrief as necessary</li> <li>Suspension/termination action review</li> <li>Post evaluation employment action/counseling</li> <li>Audit of employment related issues and actions, including Title VII, privacy, harassment, etc.</li> </ol>	<ol style="list-style-type: none"> <li>Management notification to subject of required meeting (for on-site evaluation)</li> <li>Possible post assessment treatment, referral &amp; liaison</li> <li>Post action constituency communication &amp; debrief as necessary</li> <li>Post evaluation termination</li> <li>Audit of employment related issues and actions, including Title VII, privacy harassment, etc.</li> <li>Termination action review</li> </ol>



<p><b>Treatment (Post Assessment)</b></p>	<p>1. Voluntary or required, in-patient or out-patient (possibly EAP referral) treatment for identified problems-family, marital, substance abuse or mental conditions</p>	<p>1. Voluntary or required, in-patient or out-patient, (possibly EAP referral) treatment for identified problems - family, marital, substance abuse, or mental conditions                  2. Possible treatment in conjunction with continuous fitness for duty requirement</p>	<p>1. Voluntary or required, in-patient, (possibly EAP referral) treatment for identified problems- family, marital, substance abuse, or mental conditions                  2. Possible treatment in conjunction with continuous fitness for duty requirement                  3. Possible involuntary commitment with possible involuntary medication for 72 hours or longer</p>
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## **Appendix F: Patrol Procedures**

### **1.0 Security Positions and Post Orders:**

Each security position will be assigned an area within the hospital campus, including the Hospital, Administrative Buildings, and the surrounding vicinity to conduct routine patrols, respond to security emergencies and non-emergency calls, document security related incidents, and deliver customer service that enhances the care experience for patients/residents, visitors, volunteers, and employees.

The contract security provider will develop position orders (post orders) for each position. The position orders will provide the assigned staff with the position title, day and hours of the position, special instructions pertaining to the position, emergency response information, scheduled locks and unlocks (if applicable), and areas of responsibility for special and routine patrols.

### **2.0 Interior Patrols/Building Checks:**

Interior foot patrols/building checks of the hospital campus will be conducted on a regular basis as directed by the position orders. Building-checks will include ensuring that appropriate areas are secured, checking for security and safety hazards, suspicious persons/activity, and responding accordingly.

Assigned staff will make contact with hospital staff, introduce themselves and determine if there are any security related issues they need to be made aware of.

All patrol/building check activity shall be documented in detail on the appropriate staff's daily activity report (DAR), or where applicable, the dispatch log.

2.1 During patrol/building checks, the assigned staff will promote a customer friendly environment by:

2.1.1 Watching as they approach all people, make eye contact, and provide proper greeting to persons within 10 feet.

2.1.2 Providing assistance, as necessary to persons showing outward signs of physical pain or illness, or agitation.

2.1.3 Without provoking a confrontation, stopping to investigate all suspicious persons and activity.

2.1.4 Staff assigned or roving the resident neighborhoods shall check in with the nursing staff regarding security related incidents

### **3.0 Exterior and Vehicle Patrols:**

3.1 Patrols of the campus, building exterior, grounds, parking lots and garages are to be patrolled on a regular basis as directed by the post orders. Patrols will include checking in and around vehicles, loitering activity, checking for evidence of vandalism, burglary, off property crimes, unsecured areas, smoke-free campus violations, lighting, and other safety and security concerns.

3.2 The contract security provider's staff will make contact with any suspicious persons, and vehicles on hospital/facility property, according to the contract security provider's operation procedure.

#### **4.0 Building Patrol/Security Checks Checklist:**

4.1 The following are areas that shall be included in the interior and exterior building patrols/security checks.

4.1.1 Blocked doorways

4.1.2 Doors that are taped

4.1.3 Material stuffed into the doorjamb

4.1.4 Propped doors or doors fixed so as not to close

4.1.5 Unlocked or broken locks on storage areas

4.1.6 Unsecured electrical panels

4.1.7 Exterior lights not functioning

4.1.8 Landscaping that causes a safety hazard or opportunity for crime

4.1.9 Patients that appear to have gone AWOL, in accordance with the hospital's Code Green Policy.

4.2 As required, the Facilities Department shall be notified to address facility malfunctions that result in a security breach. The contract security provider will provide security protection until the breach has been addressed.

## **Appendix G: Security Incident Report Writing and Investigation**

### **1.0 Security Incident Report Writing and Investigations**

- 1.1 When responding to a security related incident, the contract security provider/security representative will be responsible for investigating and documenting their findings on the appropriate security incident forms. Reports shall be thorough, accurate and informative.
- 1.2 A security incident report shall be completed for all incidents listed in section 4.0 of this procedure, and all reports shall be completed before the contractor security provider's staff goes off shift.
- 1.3 It is expected that each of the contract security provider's employees that respond, or receive information, complete the security incident report according to the following:
  - 4.1.1.3.1 Security Incident/Investigative Report – Completed by the security representative responsible for the initial report.
  - 4.1.2.3.2 Supplemental Report – Completed by each security representative that has additional information to the existing incident report.
  - 1.3.3 Witness Statements – Completed for all persons interviewed regarding the incident. The statements shall be signed and dated by the witness.
- 1.4 Interviewing witnesses shall be conducted in accordance with the contract security provider's operations policy.
- 1.5 A DPH specific security incident report number will be assigned to each DPH Security Investigative report. The report number will consist of the facility, year, month, and the next number listed in the incident log For example: *LHH-16-01-012*
- 1.6 The report's narrative shall fully reconstruct the circumstances based on the responding security representative's observations, witness interviews, and forensic evidence

### **2.0 Submitting and Processing the Security Incident Report:**

- 2.1 Before the end of shift or before leaving from duty, security incident reports shall be completed and submitted to the contract security provider's shift supervisor
- 2.2 The contract security provider's shift supervisor will ensure that the incident report is escalated for review in accordance with the contract security provider's operations procedures.

2.3 All security incident reports will be entered into the reporting database.

2.4 The Director of Security's office will send, electronically, all DPH security incident reports to the appropriate hospital staff and committees in accordance with the Records Retention and Disclosure Policy.

2.5 Request for criminal reports will be made to the appropriate law enforcement agency/Office of the Sheriff.

**3.0 Daily Activity Reports (DAR):**

3.1 In accordance with the contract security provider's operations procedures, a completed DAR will be submitted at the end of the shift to the contract security provider's shift supervisor. The DAR serves as a verification record of the date and time the employee worked, the employees whereabouts during the shift, response activity, time spent during service calls, and people the employee came in contact with during their shift.

3.2 The DAR is a timekeeping document used to verify the employee's actual work hours for the shift.

3.3 The DAR shall be kept current at all times, and shall never be more than one hour behind time.

3.4 Entries shall be short and simple.

3.5 Every position change, building patrolled/checked, each floor in the building patrolled/checked, and security and safety hazards shall be documented on the DAR.

**3.6 DAR CODES:**

To measure the productivity of the contract security provider's employee, the following services will be documented on the DAR:

**DAR Services:**

<u>Alarms</u>	<u>Burglar</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>
-	<u>Environmental</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>

-	<u>Fire</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>
-	<u>Help/Panic Button</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>
-	<u>Infant Abduction</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>
-	<u>Other</u>	<u>Actual</u>
-	-	<u>Human Error</u>
-	-	<u>Malfunction</u>
<u>Employee Assist</u>	-	-
<u>Local Law Enforcement On-site</u>	-	-
<u>Medical Assist</u>	<u>Emergency 911 Called</u>	-
-	<u>Non-emergency 911 Called</u>	-
-	<u>Non-emergency 911 Not Called</u>	-
<u>Motor Vehicle</u>	<u>Citation Issued</u>	<u>Parking Violation</u>
-	-	<u>Speeding</u>
-	-	<u>Reckless Driving</u>
-	-	<u>Other</u>
-	<u>Motorist Assist</u>	<u>Locate Lost Vehicle</u>
-	-	<u>Lights On</u>
-	-	<u>Valet Parking</u>
-	<u>Notice Issued</u>	-
-	<u>Towed</u>	-
<u>Personal Assist/Behavior Control</u>	<u>Employee</u>	<u>Standby</u>
-	-	<u>Restraint</u>
-	-	<u>Escort</u>

-	-	<u>Transport</u>
-	-	<u>Confidential/No Information Patient</u>
-	-	<u>CPR</u>
-	-	<u>Hold</u>
-	-	<u>Watch</u>
-	-	<u>Suicide</u>
-	<u>Patient</u>	<u>Standby</u>
-	-	<u>Restraint</u>
-	-	<u>Escort</u>
-	-	<u>Transport</u>
-	-	<u>Confidential/No Information Patient</u>
-	-	<u>CPR</u>
-	-	<u>Hold</u>
-	-	<u>Watch</u>
-	-	<u>Suicide</u>
-	<u>Visitor</u>	<u>Standby</u>
-	-	<u>Restraint</u>
-	-	<u>Escort</u>
-	-	<u>Transport</u>
-	-	<u>Confidential/No Information Patient</u>
-	-	<u>CPR</u>
-	-	<u>Hold</u>
-	-	<u>Watch</u>
-	-	<u>Suicide</u>
<b><u>Safety</u></b>	<u>Biohazard</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Burn</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Drills/Exercises</u>	<u>Fire Drill</u>

-	-	<u>Bomb Threat</u>
-	-	<u>Weapons of Mass Destruction</u>
-	-	<u>BioTerrorism</u>
-	-	<u>Other</u>
-	<u>Fall</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Other</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<u>Visitor Assist</u>	-	-

#### 4.0 Security Incident Categories:

<u>Criminal:</u>		
<u>Assault</u>	<u>On Facility Employee</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On In-Patient</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Out-Patient</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Physician</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Security Staff</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Vendor</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Visitor</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<u>Battery</u>	<u>On Facility Employee</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On In-Patient</u>	<u>No Injury</u>
-	-	<u>With Injury</u>



-	<u>On Out-Patient</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Physician</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Security Staff</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Vendor</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>On Visitor</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<b><u>Bomb Threat</u></b>	<u>Device Found</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>No Device Found</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>With Explosion</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<b><u>Burglary</u></b>	<u>Facility</u>	<u>Forced</u>
-	-	<u>Unforced</u>
-	<u>Vehicle</u>	<u>Forced</u>
-	-	<u>Unforced</u>
-	<u>Vending Machine</u>	<u>Forced</u>
-	-	<u>Unforced</u>
<b><u>Counterfeit Currency - Forgery</u></b>	<u>Bank Notes</u>	-
-	<u>Checks</u>	-
-	<u>Money Orders</u>	-
-	<u>Other</u>	-
<b><u>Death</u></b>	<u>Homicide</u>	-
-	<u>Suicide</u>	<u>Attempted/Threatened</u>
-	-	<u>Actual</u>
<b><u>Disturbing the Peace</u></b>	<u>Disorderly Conduct</u>	<u>By Facility Employee</u>

-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Labor Disturbance</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Noise Complaint</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Other</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
<a href="#">Drug/Alcohol</a>	<a href="#">Fraud</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Other</a>	<a href="#">By Facility Employee</a>

-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Possession</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Sale</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Sought</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
-	<a href="#">Use</a>	<a href="#">By Facility Employee</a>
-	-	<a href="#">By Patient</a>
-	-	<a href="#">By Visitor</a>
-	-	<a href="#">By Physician</a>
-	-	<a href="#">By Vendor</a>
-	-	<a href="#">By Other</a>
<a href="#">Harassment</a>	<a href="#">Electronic</a>	<a href="#">Against Facility Employee</a>

-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<u>Other</u>	<u>Against Facility Employee</u>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<u>Verbal</u>	<u>Against Facility Employee</u>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<u>Written</u>	<u>Against Facility Employee</u>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
<b><u>Kidnapping</u></b>	<u>Custodial Interference</u>	<u>Infant/Child Abduction</u>
-	-	<u>Other</u>
-	<u>Other</u>	-
<b><u>Off Property</u></b>	<u>Assault</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Battery</u>	<u>No Injury</u>
-	-	<u>With Injury</u>

-	<u>Burglary</u>	<u>Vehicle</u>
-	-	<u>Building</u>
-	-	<u>Other</u>
-	<u>Harassment</u>	<u>Written</u>
-	-	<u>Telephone</u>
-	-	<u>Verbal</u>
-	-	<u>Other</u>
-	<u>Other</u>	-
-	<u>Robbery</u>	-
-	<u>Sex Crimes</u>	-
-	<u>Theft</u>	<u>Pick Pocket</u>
-	-	<u>Of Auto</u>
-	-	<u>From Auto</u>
-	-	<u>From Person</u>
-	<u>Vandalism</u>	-
<u>Rape</u>	<u>Actual</u>	<u>Of Facility Employee</u>
-	-	<u>Of Patient</u>
-	-	<u>Of Visitor</u>
-	-	<u>Of Physician</u>
-	-	<u>Of Vendor</u>
-	-	<u>Of Other</u>
-	<u>Attempted</u>	<u>Of Facility Employee</u>
-	-	<u>Of Patient</u>
-	-	<u>Of Visitor</u>
-	-	<u>Of Physician</u>
-	-	<u>Of Vendor</u>
-	-	<u>Of Other</u>
<u>Robbery</u>	<u>Actual</u>	<u>Facility Employee</u>
-	-	<u>Patient</u>
-	-	<u>Visitor</u>

-	-	Physician
-	-	Vendor
-	-	Other
-	<u>Attempted</u>	Facility Employee
-	-	Patient
-	-	Visitor
-	-	Physician
-	-	Vendor
-	-	Other
<b><u>Sexual Misconduct</u></b>	<u>Lewd or Lascivious Acts</u>	Facility Employee
-	-	Patient
-	-	Visitor
-	-	Physician
-	-	Vendor
-	-	Other
-	<u>Other</u>	Facility Employee
-	-	Patient
-	-	Visitor
-	-	Physician
-	-	Vendor
-	-	Other
-	<u>Sexual Harassment</u>	Facility Employee
-	-	Patient
-	-	Visitor
-	-	Physician
-	-	Vendor
-	-	Other
<b><u>Solicitation</u></b>	-	-
<b><u>Theft - Facility</u></b>	<u>From Auto</u>	Lost/Missing
-	-	Recovered/Found

-	<u>Of Access Card</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Auto</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Bicycle</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Cash</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Computer Equipment</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Medical Equipment</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Narcotic Keys</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Narcotics</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Prescription Blank/Book</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Other</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
<b><u>Theft - Personal</u></b>	<u>From Auto</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Auto</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Bicycle</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Of Cash</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>
-	<u>Other</u>	<u>Lost/Missing</u>
-	-	<u>Recovered/Found</u>

<b><u>Threat</u></b>	<b><u>Electronic</u></b>	<b><u>Against Facility Employee</u></b>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<b><u>Other</u></b>	<b><u>Against Facility Employee</u></b>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<b><u>Verbal</u></b>	<b><u>Against Facility Employee</u></b>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
-	<b><u>Written</u></b>	<b><u>Against Facility Employee</u></b>
-	-	<u>Against Patient</u>
-	-	<u>Against Visitor</u>
-	-	<u>Against Physician</u>
-	-	<u>Against Vendor</u>
-	-	<u>Against Other</u>
<b><u>Trespass/Loitering</u></b>	<b><u>Grounds</u></b>	-
-	<b><u>Inside Buildings</u></b>	-
-	<b><u>Parking Areas</u></b>	-
<b><u>Vandalism</u></b>	<b><u>Facility Property</u></b>	-
-	<b><u>Personal Property</u></b>	-
<b><u>Weapon</u></b>	<b><u>Confiscated</u></b>	-



-	<u>Held for Safekeeping</u>	-
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**Non-Criminal:**

<b><u>Accident - Vehicular</u></b>	<u>Bicycle</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Facility Motor Vehicle</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Non-Facility Motor Vehicle</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<b><u>Animal Control</u></b>	-	-
<b><u>Fire</u></b>	<u>Actual</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Arson</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Cause Unknown</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
-	<u>Other</u>	<u>No Injury</u>
-	-	<u>With Injury</u>
<b><u>Missing Person/Patient</u></b>	<u>Adult</u>	-
-	<u>Child</u>	-
<b><u>Property - Facility</u></b>	<u>Confiscated</u>	-
-	<u>Damaged</u>	-
-	<u>Lost/Missing</u>	<u>Access Card</u>
-	-	<u>Narcotics Keys</u>
-	-	<u>Facility Keys</u>
-	<u>Other</u>	-
-	<u>Recovered/Found</u>	-
-	<u>Serviced</u>	<u>Doors</u>
-	-	<u>Cash Escort</u>
-	-	<u>Chart Run</u>
-	-	<u>Area Check</u>

-	-	<u>Flags</u>
-	-	<u>Mail Pickup/Drop Off</u>
-	-	<u>Power Outage</u>
-	-	<u>Water Leak</u>
<b><u>Property - Personal</u></b>	<u>Confiscated</u>	-
-	<u>Damaged</u>	-
-	<u>Lost/Missing</u>	-
-	<u>Other</u>	-
-	<u>Recovered/Found</u>	-
<b><u>Suspicious Activity</u></b>	<u>Contacted by Security Services</u>	<u>Person</u>
-	-	<u>Misuse of Access Card</u>
-	-	<u>Misuse of Member Card</u>
-	-	<u>Vehicle</u>
-	-	<u>Package or Object</u>
-	-	<u>Other</u>
-	<u>No Contact</u>	<u>Person</u>
-	-	<u>Misuse of Access Card</u>
-	-	<u>Misuse of Member Card</u>
-	-	<u>Vehicle</u>
-	-	<u>Package or Object</u>
-	-	<u>Other</u>

## **Appendix H: Visitors Screening Process**

### **1.0 Scope:**

Applies to all clinic staff and physicians throughout the campus, including the inpatient care units, rehabilitation and wellness centers, patient/resident neighborhoods and other areas on campus. The provisions of this procedure apply to all visitors and vendors entering Laguna Honda Hospital and Rehabilitation Center.

### **2.0 Procedure:**

2.1 During visiting hours, the contract security provider will verify, obtain authorization, log visitors, and issue visitor passes to all authorized visitors.

2.2 If a physician has specified that visitors would not be in the best interest of the patient/resident, the contract security provider will support the physician in communicating with the patient's/resident's decision maker.

2.3 If isolation precautions are required, the contract security provider will support the neighborhood's nursing staff, when advising visitors of the necessary precautions.

2.4 The Nursing Office/Neighborhood Resident Care Team will address special considerations to visitors for residents/patients with visiting restrictions.

2.4.1 Visitation restrictions or prohibition will be enforced without regard to race, ethnicity, color, national origin, ancestry, religion, culture, language, sex (including gender, gender identity, gender expression), sexual orientation, age, genetic information, marital status, registered domestic partner status, veteran's status, medical condition, socioeconomic status, educational background, physical or mental disability, or the source of payment of care.

### **3.0 Limitations on Visitors**

3.1 Refer to the LHPP 24-07 Visiting policy.

3.2 Two visitors at one time are preferred.

3.3 Space constraints may limit the number of visitors.

### **4.0 Visiting Hours**

4.1 Regular visiting hours are daily, from 10:00 AM – 9:00 PM.

### **5.0 Visitor Screening and Authorization**

5.1 The contract security provider's staff will determine the floor/department that the person will visit and call for authorization as required.

4.1.15.1.1 If authorization is granted, using the visitors pass kiosk, the officer will issue a visitor's pass.

4.1.25.1.2 If the visitor's kiosk malfunctions, the security officer will log the visitor's information on the visitors pass log and issue the appropriate visitors pass.

5.1.3 If authorization is not given, the officer will inform the visitor.

**6.0 Visitor Pass Log**

**Laguna Honda Hospital and Rehabilitation Center**  
**VISITOR PASS LOG**

<u>DATE:</u>	<u>SECURITY REPRESENTATIVE:</u>	<u>POSITION:</u>
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<u>VISTOR PASS</u>	<u>PATIENT/RESIDENT, DEPARTMENT NAME</u>	<u>RLTN TO PATIENT</u>	<u>VISITOR NAME</u>	<u>ROOM#</u>	<u>TIME</u>

## Appendix I: Arrest Procedure

**1.0 Arrest by a Private Citizen:** It is expected that the security provider, when responding to an incident involving an arrest explain the following to the private citizen:

### 1.1 Authority (P.C. 834, 837)

1.1.1 Any private citizen has the authority to make an arrest when the following incident occurs:

1.1.1.1 For a public offense committed or attempted in their presence.

1.1.1.2 When the person arrested has committed a felony, although not in his/her presence.

1.1.1.3 When a felony has been in fact committed, and the private citizen has reasonable cause for believing that the person to be arrested committed the act.

1.1.2 Whenever any person is summoned to the aid of any uniformed peace officer, such a person shall be vested with such powers of a police officer as are expressly delegated him/her by the summoning officer or as are otherwise reasonably necessary to properly assist such officer. (P.C. 839)

1.1.3 Any person making an arrest may orally summon as many persons as they deem necessary to aid them in the arrest.

1.1.4 A private citizen can use a reasonable amount of force in affecting a citizen's arrest when there is reason to believe the person being arrested is resisting arrest.

1.1.5 Reasonable force is defined as only that force necessary to affect the arrest, or protect oneself from a violent attack.

1.1.6 Excessive force is more than the force necessary to affect the arrest or protect oneself from a violent attack.

1.1.7 Any person making an arrest may take from the person arrested all offensive weapons which they have on their person, and shall deliver them to a law enforcement officer (typically on site).

1.1.8 An arrest is made by the actual restraint of the person, or by submission to the custody of the person making the arrest. The person arrested may be subjected to such restraint as is reasonable for their arrest and detention.

1.1.8.1 The person making the arrest shall inform the person to be arrested of the intention to arrest them, the cause of the arrest, and the authority to make it, except:

1.1.8.1.1 When the person making the arrest has reasonable cause to believe that the person to be arrested is actually engaged in the commission, or an attempt to commit a felony offense or when a misdemeanor offense has been committed in their presence

1.1.8.1.2 The person to be arrested is pursued immediately after its commission, or after an escape.

1.1.8.1.3 The person making the arrest, shall on request of the person he/she is arresting, informs the latter of the offense for which he is being arrested.

1.1.9 A private citizen who has arrested another for the commission of a public offense shall, without unnecessary delay, deliver the person to a Peace Officer.

1.1.10 The private citizen shall complete an Arrest by Private Person form (SFSD Form 520.517).

1.1.11 The person making the arrest shall prove to the satisfaction of the court of law that the arrest was made in good faith, only after the arresting individual personally knew that the acts were committed in violation of a specific criminal law, State or Federal, the person apprehended committed the offense.

1.1.12 The person making the arrest is personally responsible, both criminally and civilly, for any false arrest. Thus, such persons are subject to defend a legal action in a claim of damages growing out of a false arrest.

**2.0 Arrest by a Peace Officer:** The security supplier's staff with peace officer authority shall conduct the arrest in accordance with the law as listed below:

### **2.1 Authority (P.C. 834, 836)**

2.1.1 A peace officer "may" make an arrest under the following circumstances:

2.1.1.1 Pursuant to an arrest warrant.

2.1.1.2 Whenever the officer has reasonable (or probable) cause to believe the suspect has committed a crime.

2.1.1.3 Whenever the officer has reasonable (or probable) cause to believe a crime has in fact been committed.

2.1.2 Note that only "reasonable" or "probable" cause is needed: The fact that the officer may be mistaken as to defendant's guilt, of that a crime even occurred, is irrelevant so long as the arrest is made with probable cause to believe one is guilty and that a crime occurred. The arrest would still be lawful.

2.1.3 The use of the word "may" in the statute indicates that the officer is under no obligation to make an arrest. It is a matter of discretion whether or not, despite the existence of "probable cause," an arrest will be made. An officer is not generally required to arrest an individual despite the officer's determination that an arrest could legally be made.

2.1.4 "Posse Comitatus:" Further, a uniformed peace officer, or any peace officer has statutory authority to command any "able-bodied" individual over the age of 18 to assist in an arrest. (P.C. 150)

2.1.5 In a domestic violence situation, a peace officer:

2.1.5.1 Shall make a good faith effort to explain to the victim/witness of his or her right to make a private person's arrest; or

2.1.5.2 When responding to a situation involving the violation of a domestic violence restraining or protective order.

## 2.2 Reasonable Force (P.C. 835a):

2.2.1 Any peace officer who has reasonable cause to believe that the person to be arrested has committed a public offense may use reasonable force to effect the arrest, to prevent escape or to overcome resistance.

2.2.2 A peace officer who makes or attempts to make an arrest need not retreat or desist from his efforts by reason of the resistance or threatened resistance of the person being arrested; nor shall such officer be deemed an aggressor or lose his right to self-defense by the use of reasonable force to effect the arrest or to prevent escape or to overcome resistance.

## 2.3 Deadly Force (Section 13-410):

2.3.1 The use of deadly force by a peace officer against another is justified pursuant to section 13-409 only when the peace officer reasonably believes that it is necessary:



2.3.1.1 To defend himself or a third person from what the peace officer reasonably believes to be the use or imminent use of deadly physical force.

2.3.1.2 To effect an arrest or prevent the escape from custody of a person whom the peace officer reasonably believes:

2.3.1.2.1 Has committed, attempted to commit, is committing or is attempting to commit a felony involving the use or a threatened use of a deadly weapon.

2.3.1.2.2 Is attempting to escape by use of a deadly weapon.

2.3.1.2.3 Through past or present conduct of the person which is known by the peace officer that the person is likely to endanger human life or inflict serious bodily injury to another unless apprehended without delay.

2.3.1.2.4 Is necessary to lawfully suppress a riot if the person or another person participating in the riot is armed with a deadly weapon.

2.3.1.3 Notwithstanding any other provisions of this chapter, a peace officer is justified in threatening to use deadly physical force when and to the extent a reasonable officer believes it necessary to protect himself against another's potential use of physical force or deadly physical force.

#### **2.4 Excessive Force Definition:**

2.4.1 Excessive force refers to force in excess of what a peace officer reasonably believes is necessary. A peace officer may be held liable for using excessive force in an arrest, an investigatory stop, or other seizures. A peace officer may also be liable for not preventing another peace officer from using excessive force.

2.4.2 Whether the peace officer has used force in excess of what he reasonably believed necessary at the time of action is a factual issue to be determined by the jury.

#### **3.0 Security Provider Reporting Responsibilities:**

3.1 It is expected that the contract security provider upon conclusion of an incident resulting in an arrest or use of force take the following actions:

3.1.1 Notify hospital administration, including Administrator on Duty (AOD), Chief

Operations Officer, and the DPH Director of Security

3.1.2 By the end of shift, complete an incident report, including supplemental reports of all responding staff, written statements from all reporting witnesses, and forensic evidence.

3.1.3 By the end of shift, the arrest report (or preliminary report) will be submitted to the security provider's Unit Commander. The Unit Commander will report the incident to the DPH Director of Security.

**4.0 Jurisdiction**

4.1 The security provider is authorized to pursue/investigate incidents outside of LHH property when the following exist:

~~4.1.3~~4.1.1 Pursuit shall take place without unreasonable delay after a felony offense on LHH property has been committed.

4.1.2 Within the geographical limits of LHH property in accordance to the security supplier's written protocol.

4.1.3 When appropriate, in pursuit of an "AT RISK" patient.

## **Appendix J: Laguna Honda Hospital and Rehabilitation Center Security Training Program**

**1.0 Each of the contract security provider's employees shall complete hospital orientation, and participate in an ongoing hospital security training program, which will include the following:**

**1.1 A six week, contract security provider developed, and delivered field training officer program (FTO), including the following subjects:**

**1.1.1 New Employee Orientation**

**1.1.2 Emergency Preparedness**

**1.1.3 Care Experience Training**

**1.1.4 Security Operation Procedures**

**1.1.5 Tour of the Hospital Campus**

**1.1.6 Hospital Organizational Structure**

**1.1.7 Use of Standard Precautions**

**1.1.8 Smoke Free Campus**

**2.0 Each of the contract security provider's supervisors, including commanding officer shall complete the following:**

**2.1 International Association for Healthcare Safety and Security's Basic and Supervisor Training Course,**

**2.2 Annual Emergency Preparedness Training;**

**2.3 Annual Core Competency Refresher Training as determined by the contract security provider's commanding officer.**

**3.0 Documentation of the training will be maintained onsite, and produced during regular compliance audits/regulatory investigations**

**4.0 Supervisors, Managers, Directors, and Administrators will ensure that the above list of policies are enforced among employees within their departments and with contractors.**

## **Appendix K: Enforcement of the Smoking Policy**

### **1.0 Enforcement of the Smoking Policy:**

All employees, physicians, volunteers, and contractors share the responsibility to respect and assist in enforcing this policy. Any individual found violating this policy shall be politely informed of the facility No Smoking Policy and asked to extinguish the item or move to a location off of campus.

1.1 If the smoker refuses to extinguish their item, the contract security provider's staff shall be notified of the location of the smoker, and shall respond to enforce the policy.

1.2 The contract security provider shall perform patrols throughout the campus on an ongoing basis to ensure adherence to this policy. If the security representative identifies any person in violation of this policy, they will enforce the policy as described in the hospital's Smoking Free Campus Procedure.

1.3 Supervisors, Managers, Directors, and Administrators will ensure that this policy is enforced among employees within their departments and with contractors.

## Appendix L: Response to Internal and External Emergency Disasters

### 1.0 Response To Internal And External Emergency Disasters

1.1 The purpose of the Laguna Honda Hospital and Rehabilitation Center Plan is to identify routine security operation procedures and describe procedures for escalation security protection during emergency and disaster incidents, and permit the continuance of current operational functions with minimal interruptions to our employees, patients/residents and volunteers. The emergency operation plan identifies the organization's capabilities and establishes response efforts when the organization cannot be supported by the City and County of San Francisco community services for at least 96 hours.

### 2.0 Threat Assessment Process

2.1 The focal point for routine or special intelligence gathering and dissemination will be conducted by the Department of Public Health and the contractual security provider. Information will be gathered, evaluated, and presented to the Director of Security and Executive Administrator, Administrator-On-Duty, the contract security provider, and the other hospital administration, as appropriate.

2.1.1 Laguna Honda Hospital and Rehabilitation Center (LHH) will rely on Federal, State and local authorities, including the contract security provider for receipt of credible threat warnings. LHH will immediately share information with the appropriate governmental agencies to validate the credibility of a threat or warnings gathered through official and open sources. Credible intelligence will be discussed by the Director of Security with the LHH Executive Administrator, or their designee before recommending a protection level change for the program or for a selected facility (ies) within the program.

2.1.2 Under exigent circumstances, where there is an imminent threat or an internal/external disaster occurs, local hospital, and Department of Public Health (DPH) communications will be initiated. The local hospital and vice-versa shall communicate per standard operating procedures. The campus-wide execution of the LHH Security Enhancement Plan, will be executed under the direction of the Department of Public Health's Director of Security or designated representative, and in conjunction with the contract security provider's commanding officer, and after coordination with the appropriate San Francisco City and County Leadership.

2.1.3 Implementation of an enhanced PROTECTION level will be based on real-time credible intelligence gathered through the news media, the contract security provider, Federal, State, and City law enforcement agencies, the DPH Director of Security, hospital administration, and the Department of Public Health leadership.

- 2.1.4 Threats that fall under the Violence in the Workplace Policy require that all employees, physicians, and management staff report any incident where they:
  - 2.1.4.1 Believe they have been the subject of actual or threatened violence, or
  - 2.1.4.2 Have observed or otherwise learned of such conduct by any person employed by LHH, using LHH services, or on LHH premises.
- 2.1.5 These incidents shall be reported to the Administrator-On-Duty, Executive Administrator, Chief Operations Officer, and DPH Director of Security.
  - 2.1.5.1 Incidents to be reported include acts or threat of violence which manifest themselves in the workplace; acts or threats of violence stemming from work-related issues which manifest themselves either within or outside the workplace environment; and acts or threats of violence which may be unrelated to the workplace but which manifest themselves within the workplace.
  - 2.1.5.2 Laguna Honda Hospital and Rehabilitation Center is responsible for developing a Violence Prevention Plan and designating a core group of individuals known as the Campus Security and Safety Committee who will be responsible for plan implementation in response to any reports or actions by employees, patients, or other persons which are or may be in violation of this policy. Such plans shall meet the requirements of state and federal law and regulations including, but not limited to, the California Occupation Health and Safety Act and California Health and Safety Code 1257.7 & 1257.8 (Hospital Security Act).
- 2.1.6 A protocol for an immediate follow-up plan to actual acts and/or threats of violence shall include the following elements:
  - 2.1.6.1 Designation of appropriated levels of authority for decision making.
  - 2.1.6.2 Prompt, thorough, factual and coordinated investigation of all reports.
  - 2.1.6.3 Consideration of privacy and confidentiality issues. Notification shall be strictly limited to those persons who have a need to know, to include those individuals administering the Threat Management Plan, potential identifiable victims of the threat, local police

authorities and administrative staff.

2.1.6.4 Conscientious designation of persons who shall receive confidential reports related to the incident.

2.1.6.5 Early and continuing assessment of the seriousness of the situation. This assessment shall include an evaluation of the type of risk, the natures and severity of the potential harm, the likelihood that the potential harm will occur and the imminence of the potential harm.

2.1.6.6 Coordination with DPH leadership and resources as appropriate.

2.1.6.7 Utilization of fitness for duty, other psychological examination, or collateral interviews with witnesses or victims for fact finding and/or risk assessments.

2.1.6.8 Confidential counseling and other support services for victims and witnesses separated from any fact finding and/or risk assessment functions.

2.1.6.9 Timely and reasonable response to the situation following an assessment of all facts identified during the investigation.

2.1.6.10 Appropriate case response for varied situations (e.g. critical incident stress debriefing or threat response).

2.1.7 Security and safety assessment as required by California Health & Safety Code Section 1257.7 & 1257.8 for Hospitals and Emergency Departments, including an assessment of trends of aggressive and violent behavior and required training for staff, periodic re-evaluation of physical security applications (e.g. access control procedures, camera installation alarms or distress buttons), and the establishment of a viable security management plan that will ensure a sustained level of security preparedness in vulnerable areas.

### 3.0 Report And Alert Procedures

3.1 Once credible intelligence is received, the Director of Security and the contract security provider's commanding officer will be notified. The Director of Security will brief key executives. Protection Level is then implemented as well as the Internal Crisis Communications Plan.

3.1.1 In a serious incident, the Security Operations Center (SOC) shall notify the contract security provider's chain of command in accordance with their operations procedure. The Director of Security shall be notified according

to the Serious Event Notification Procedure.

3.1.2 For incidents that occur after hours the SOC in coordination with the contract security provider's shift supervisor will gather all information known at that time, and contact the Administrator-On-Duty, including providing updates as they occur.

3.1.2.1 Operator Services shall be contacted and informed of the incident as required.

3.1.2.2 All security specific messages will be classified "Confidential," and will direct the information to be disclosed only to those authorized personnel with a "need to know"

#### 4.0 Emergency Security Operations

4.1 The contract security provider's commanding officer shall be notified to request additional contract security staff

4.2 LHH representatives who are authorized to make this request are

4.2.1 DPH Director of Security

4.2.2 Executive Administrator

4.2.3 Chief Operations Officer

4.2.4 Administrator-On-Duty

4.3 Incident Command Center (ICC), Security Operations Procedures

4.3.1 Depending on the scale of the impact at LHH, the ICC would be activated to support other DPH facilities and serve as a guiding resource.

4.3.2 Initially the role of the ICC will be to facilitate data collection, verification and evaluation of situation status, and communication. The ICC will then present data and decisions back to the appropriate leaders, and departments as well as communication externally on behalf of LHH as a whole. ICC will coordinate mutual aid requests between operational areas within DPH. (This includes the coordination of all mutual aid requests other than that provided through established discipline-specific systems such as the Disaster Medical/Health, City Law Enforcement and Fire and Rescue Mutual Aid Systems). Receive and disseminate emergency alerts and warnings.

#### 5.0 Field Operations Procedures



5.1 Primary Responsibilities of the contract security provider:

5.1.1 Monitor and have authority over the safety and rescue operations and hazardous conditions.

5.1.2 Organize and enforce scene/facility protection and traffic safety.

5.1.3 Provide appropriate presence in the area of traffic and pedestrian control, crowd and access control, secure food, water, medical and blood resources, and establish routine briefings with hospital administration and the ICC.

5.2 Primary Responsibilities of the Security Director and Contract Security Provider's Commanding Officer:

5.2.1 The Director of Security and Commanding Officer is expected to implement emergency procedures to ensure the safety of all staff, patients and visitors. These responsibilities are not limited to the individual departments, but extend throughout the entire medical center as outlined in the Emergency Preparedness Security Officer's Checklist.

5.3 Based upon the protection level assigned:

5.3.1 Protection Level 1- At this stage, the disaster casualties will be geographically contained, as determined by the ICC. Additional demands would be for staff and supplies only (Defined as a disaster of unknown magnitude). However, available information indicates that normal hospital resources are adequate to handle the incident: The contract security provider will assign staff to address traffic control, divert visitors, and personnel, and divert unauthorized personnel.

5.3.2 Protection Level 2- A Level II internal disaster is different from the Level I disaster in that the Incident Command Center (ICC) is partially activated and treatment areas are established. A Level II external disaster is defined as an incident involving more than one DPH facility, or a disaster in the community that has the potential of exceeding the normal resources of departments within the hospital.

5.3.2.1 The ICC is partially activated. The entire ICC team is not activated initially. All departments are notified accordingly. Additional staff is called, as needed. The SOC will notify the Commanding Officer, Administrator-On-Duty, Director of Security, and the Contract Security Provider's, Shift Supervisor, and staff.

5.3.2.2 All staff and employees remain on-site and continue routine work. Initially the contract security provider's staff will report in to the

SOC/Shift Supervisor for instructions. Visitors and outpatients may remain in the building.

5.3.3 Protection Level 3-5 - All contract security provider personnel will receive assignments by their chain-of-command.

5.3.3.1 A Level III disaster is different from a Level I or II in that the ICC is fully activated. A Level III means a large disaster, some 50 to 150-plus casualties. The contract security provider will provide protection to the perimeters of all buildings, secure the hospital and all other buildings, provide crowd control, access control, and establish a presence.

5.3.3.2 Depending on the circumstances of the event, contract security law enforcement services in conjunction with City law enforcement will establish a security zone around the hospital perimeter, crowd control, traffic control on public streets, establishing security check points to control access to the hospital campus.

5.3.3.3 Shall the responding City law enforcement agency initiate its Incident Command structure, then Hospital Incident Command, the Contract Security Provider's incident command, and City Law Enforcement Incident Command would create a Unified Command structure. The Unified Command enables coordination of tasks and resources between the various entities.

## 6.0 Special Purpose Areas For Security Staffing Considerations

6.1 Triage Area

6.2 Treatment Areas

6.3 Morgue Area

6.4 Media Center

6.5 Labor Pool

~~6-5~~6.6 Command Center

~~6-6~~6.7 Parking Areas

6.8 Facility Areas i.e. Central Plant, Food and Water Supply areas

## 7.0 Special Duties – Security Services

7.1 Establish two-way radio communication in the ICC

7.2 Secure the perimeter of impacted area(s)

7.3 Stand by the media center (if designated)

7.4 Media shall not be allowed to enter into the building without the specific authorization of the Public Information Officer or designee.

## **Appendix M: Security Service Department Job Descriptions**

### **1.0 Contract Security Provider Job Descriptions:**

#### **1.1 Commanding Officer**

- 1.1.1 The Commanding Officer manages the security and law enforcement services, to all DPH facilities, including client service, problem resolution, and operational effectiveness, preparation of post orders, staffing, scheduling, supervision and training.
- 1.1.2 Implements and oversees the security operation, including the supervision of all assigned staff and supervisors.
- 1.1.3 Implements and oversees the process for incident report and investigations.
- 1.1.4 Assists with the functions of physical and personal security and safety measures of patients, staff, and visitors.
- 1.1.5 Protects staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.
- 1.1.6 Makes regular hospital and clinic service rounds to solicit feedback regarding the contract security provider's service to internal and external customers. Service rounding will be documented, and submitted to the Director of Security.
- 1.1.7 Preserves order and may enforce regulations pertaining to personnel, patients, and visitors on Laguna Honda Hospital and Rehabilitation Center premises.

### **2.0 Contract Security Provider's Shift Supervisor:**

- 2.1 The contract security provider's shift supervisor is responsible for implementing and overseeing the security operation during their scheduled shift by:
  - 2.1.1 Directing and supervising all assigned staff's activity.
  - 2.1.2 Reviewing all daily activity and incident reports.
  - 2.1.3 Interfacing with hospital administrators, managers, and supervisors as required.
  - 2.1.4 Responding to all security related emergencies and coordinate communications with hospital administration, and their commanding

officer.

2.1.5 Assisting with the functions of physical and personal security and safety measures of patients, staff, and visitors.

2.1.6 Protecting staff and property from theft or damage, persons from hazards or interference, including the potential for violence in the workplace.

2.1.7 Making periodic tours to check for irregularities, and inspecting protection devices.

2.1.8 Preserving order and enforcing regulations pertaining to personnel, visitors, and premises as warranted.

### **3.0 Contract Security Provider's Leadership Staff**

3.1 The contract security provider's leadership staff is responsible for assisting with the functions of physical and personal security and safety measures of patients, staff, and visitors by:

3.1.1 Protecting staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

3.1.2 Primary functions include being a first responder to emergency situations at the assigned healthcare facility.

3.1.3 Making periodic tours to check for irregularities and inspecting protection devices.

3.1.4 Preserving order and enforcing regulations pertaining to personnel, visitors, and premises as warranted.

3.1.5 In the absence of the contract security provider's shift supervisor, assuming their responsibilities.

### **4.0 Contract Security Provider's Training Coordinator**

4.1 The contract security provider's training coordinator is responsible for planning, coordinating, and delivering training to all assigned staff by:

4.1.1 Conducting monthly proficiency drills related to the security response of all assigned staff.

4.1.2 Conducting annual competency assessments for all assigned staff.

4.1.3 Supervising and assessing assigned staff's response to security related incidents.

4.1.4 Adapting training programs for specific sites and client's needs.

4.1.5 Implementing conducting and overseeing Emergency Preparedness Training Programs.

4.1.6 Coordinating training that focuses on defusing aggressive behavior for assigned staff, and client personnel as needed or as directed.

## **5.0 Contract Security Provider's Radio Dispatch Operator**

5.1 The contract security provider's dispatch operators are directly responsible for answering telephones, acknowledging alarm signals, monitoring video recording devices as assigned throughout the assigned department by:

5.1.1 Providing information to the Security Systems Administrator, supervisor and assigned staff as required.

5.1.2 Documenting security related incidents, and responding to security emergencies.

5.1.3 Responding to service calls by dispatching appropriate staffing.

5.1.4 Assisting with security device inspections.

5.1.5 Assisting with producing forensic evidence as directed by the Commanding Officer, or Director of Security.

5.1.6 Assisting with the functions of physical and personal security and safety measures of staff, patients, and visitors.

5.1.7 Assisting with the protection of staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

## **6.0 Contract Security Provider's Telephone Operator**

6.1 The contract security provider's dispatch operators are directly responsible for answering telephones, acknowledging alarm signals, monitoring video recording devices as assigned throughout the assigned department by:

6.1.1 Providing information to the Security Systems Administrator, supervisor and assigned staff as required.

- 6.1.2 Documenting security related incidents, and responding to security emergencies.
- 6.1.3 Responding to service calls by dispatching appropriate staffing.
- 6.1.4 Assisting with security device inspections.
- 6.1.5 Assisting with producing forensic evidence as directed by the Commanding Officer, or Director of Security.
- 6.1.6 Assisting with the functions of physical and personal security and safety measures of staff, patients, and visitors.
- 6.1.7 Assisting with the protection of staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

## **7.0 Contract Security Provider's Uniformed Patrol and Security Service Staff:**

- 7.1 The contract security provider's patrol, and security service staff is responsible for being a first responder to emergency situations at the healthcare facility by:
  - 7.1.1 Documenting all security related incidents.
  - 7.1.2 Responding to security emergencies.
  - 7.1.3 Making periodic tours to secure areas, providing customer service, mitigating disruptive behavior, deterring crimes, and providing non-violent crisis intervention, until such time that an incident requires the use of force, which will be conducted in accordance with the contract security provider's operation procedures.
  - 7.1.4 Inspecting protection devices as required and checking for irregularities.
  - 7.1.5 Preserving order and enforcing regulations pertaining to personnel, visitors, and premises as warranted.
  - 7.1.6 Assisting with the functions of physical and personal security and safety measures of patients, staff, and visitors.
  - 7.1.7 Protecting staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

## **8.0 Security Administrative Specialist (DPH Position)**

8.1 The Security Administrative Specialist is responsible for administrative functions including:

8.1.1 Incident Report processing, record keeping, and filing, reception, compilation of data for reports, and tracking statistics.

8.1.2 Monitoring LHH security personnel compliance.

8.1.3 Data entry.

8.1.4 Other miscellaneous and/or ancillary tasks as assigned by the Director of Security.

## **9.0 Security Systems Administrator (DPH Position)**

9.1 The Security Systems Administrator oversees the implementation of hospital's security systems and technology integration by:

9.1.1 Consulting.

9.1.2 Assisting and tracking master system architecture for DPH facilities in order to achieve logical collective implementation.

9.1.3 Providing Contractor/Local support for programming or bringing systems into operations.

9.1.4 Maintaining Security System Server Software Licensing.

9.1.5 Providing liaison for Local Security and Systems designers and manufacturers.

9.1.6 Ensuring design/construction projects are consistent with industry best practices as well as industry design standards, scope, schedule and budgets.

9.1.7 Reinforcing the direction of hospital facility systems, and developing relationships with IT, Facilities, the Contract Security Provider, and Contractors in order to maintain system efficiencies.

9.1.8 Conducting monthly inspections of the hospital security system to ensure functionality.

9.1.9 Implementing the security operation center's program which includes the following:

9.1.9.1 Overseeing the security operation center functions.



- 9.1.9.2 Producing audit reports, and forensic evidence during investigations.
- 9.1.9.3 Assisting with the functions of physical and personal security and safety measures of patients, staff, and visitors.
- 9.1.9.4 Making periodic tours to check for irregularities and inspecting protection devices.

## Appendix N: Identification of Employee, Patients/Residents and Volunteers

### 1.0 Identification of Employees, Patients And Visitors

The following establishes a photo identification badge process that allows immediate identification of employees and physicians by patients, staff, physicians, volunteers, and visitors during the course of work, and complies with Title 22, Senate Bill 956, and Assembly Bill 1439.

1.1 **Scope:** This policy applies to all LHH employees, consultant physicians/providers, contractors and volunteers.

#### 1.2 Procedure: Requesting an Employee Photo Identification Badge:

~~4.1.1~~ 1.2.1 Obtain a Badge/Access Card Request Form from Human Resources.

~~4.1.2~~ 1.2.2 Fill out the form completely, including the appropriate employee and manager signatures.

1.2.3 Turn in the completed Badge/Access Card Request form to Facility Services.

### 2.0 Human Resource and Facilities Processing and Distribution of Employee Badges

2.1 Process Badge/Access Card Request Forms

2.2 Badges will include the following information: first name, or initial of the first name, last name, license, or certified title of all physicians, licensed health care professionals, and other certified health care professionals working at LHH. Professional title and department will be displayed, as appropriate. All badge lettering will be in 18-point type.

2.3 Employees are issued an initial badge at no charge. The cost to the employee for the replacement of lost badges is \$10.00. **Stolen badges are replaced at no charge.**

2.4 The replacement of a badge for a change in name or title or to for a damaged badges will done for no charge.

2.5 Issue ID Badge to the Employee.

### 3.0 Wearing the Employee Photo Identification Badge

- 3.1 The photo identification badge is to be worn at all times while on hospital property or in the process of providing services on behalf of the LHH, which includes traveling to and from parking structures and their workplace. The photo identification badge shall be worn on the upper half of the body with the name and photograph clearly visible.
- 3.2 Managers are to inform staff about this policy and the expectation that the photo identification badge is worn during the course of work.
- 3.3 Managers will ensure that employees wear their photo identification badge on the upper half of the body with the name and photo identification clearly visible.
- 3.4 All LHH campus employees are expected to question suspicious individuals and immediately report to the contract security provider and the department manager or supervisor.
- 3.5 To safeguard the badge, to prevent loss and ensure effective security, badges shall not be worn off premises, left on unattended clothing, or otherwise unsecured.

#### **4.0 Requesting a Temporary Employee Identification Badge**

- 4.1 Employees who fail to bring their badges to work shall inform their immediate supervisor upon entry into the workplace.
- 4.2 The employee's supervisor or designee will inform Facility Services Department that the employee needs a temporary badge. The supervisor or designee will verify that the person is employed with LHH, and is scheduled to work.
- 4.3 The employee shall show California identification and submit the California ID in exchange for the temporary identification badge, and sign the temporary ID log prior to receiving the temporary ID.
- 4.4 The facility department staff will log-in the employee and the supervisor's name on the temporary identification badge log then take possession of the employee's California Identification.
- 4.5 The employee will wear the temporary badge in a visible location on the upper half of the body until the end of the shift.
- 4.6 At the end of the shift the employee will return to the Facility Services Department to return the temporary badge, receive their California ID, and sign the temporary badge log verifying receipt of their California identification.

- 4.7 The facilities staff will receive the temporary identification badge at the end of the shift and return the employee's California identification upon receipt of the signature from the employee.
- 4.8 Because the temporary badge does not have a photo or the name of the employee, concerned parties will be able to confirm the employee's name and title by calling the Facility Services Department at (415) 759-2369, (The phone number will be noted on the temporary badge) and provide the temporary badge number and the date that the employee is working.
- 4.9 If the employee later determines that their badge has been lost or stolen the employee shall immediately notify Facility Services to arrange to receive a replacement badge.

#### **5.0 Recovery of Employee Photo Identification and Access Cards upon Transfer or Termination:**

- 5.1 The identification badge is the property of LHH, and shall be returned to the department manager or supervisor upon termination, resignation, or transfer from the facility.
- 5.2 Managers will inform staff about the policy and the expectation to return photo identification cards and access cards prior to termination, transfer, or retirement.
- 5.3 Managers will obtain photo identification badges and access cards from staff prior to leaving the premises on the last day of work. Badges and access cards shall be returned to the Facility Services Department.
- 5.4 If the employee leaves without notice or fails to turn in his/her badge, the manager will call the Human Resources and the Facility Services Department immediately.
- 5.5 Immediately upon being notified that an employee failed to turn in their badge, Facility Services Department will deactivate the badge/access card.
- 5.6 A monthly report listing all employee, physician, and contract worker, transfers, and terminations will be submitted to the Facility Department by Human Resources for reprogramming/deactivation of badges.

#### **6.0 Resident/Patient Identification**

To ensure proper identification of patients receiving care, treatment, or services at LHH, all resident/patients are identified at the point of initial contact upon registration or admission using at least two patient identifiers (neither to be the patient's room number or physical location).

Two patient identifiers will be used whenever administering medications or blood products, collecting blood samples and other specimens for clinical testing, or providing other treatments or procedures. A defined process and procedure will be followed in the management of patient identification. Containers used for blood and other specimens are to be labeled in the presence of the patient.

#### 6.1 Resident/Patient Identification Process (Initial Identification)

All in- and outpatients receiving care at LHH are asked to provide identification upon presentation to the hospital. A combination of two identifiers from those listed is used to confirm the patient's identity. The following approved identifiers and sources may be used for positive identification:

~~5-6-1~~ 6.1.1 patient name

~~5-6-2~~ 6.1.2 date of birth

~~5-6-3~~ 6.1.3 medical record number

~~5-6-4~~ 6.1.4 medical record card

~~5-6-5~~ 6.1.5 government issued photo identification

~~5-6-6~~ 6.1.6 last four digits of the social security number

6.1.7 Sources of resident/patient identifiers may include: the resident/patient, relative, guardian, domestic partner, or a health care provider who has previously identified the patient.

6.2 An identification band will be placed on all inpatients/residents as part of the admission process on the care unit/neighborhood.

6.3 The preferred placement of the resident/patient ID band is the upper extremity (right arm preferred) unless physical condition or procedure precludes this (in which case another extremity is used).

#### 6.4 Resident/Patient Identification Reconfirmation

Two unique identifiers will be used at LHH to reconfirm patient identification prior to every instance of administering medications or blood products, taking blood samples and other specimens for clinical testing, or performing other treatments or procedures:

6.4.1 The patient's full name and date of birth on the identification band will be checked against the identifiers on the requisition, medication or specimen collection container label.

## 6.5 Patient Identification Procedure

The initial identification process will be performed by hospital personnel, who will then apply a patient identification band.

6.5.1 The Admitting Office staff shall place the plastic identification band on each patient. Patients admitted directly to an inpatient unit shall have the identification band placed by nursing personnel immediately upon receiving the ID band. Nursing personnel shall perform the initial identification process before placing the ID band.

## 6.6 Patient Identification Band

The patient identification band shall remain on the patient until discharge. If an ID band shall be removed for procedural access or other clinical circumstance, another ID band is obtained prior to removing the original, the information is verified by comparing the patient identifiers on the new band with that of the band to be removed, and ID band is replaced at an alternate site.

If at any time, the patient is found to not have an ID band, the initial identification process shall be performed and a replacement ID band applied.

## 6.07.0 Visitor Passes

7.1 All visitors authorized to enter the hospital will be issued a visitor's pass by the contract security provider.

## **Appendix O: Personal Safety and Cash Escorts**

### **1.0 Personal Safety Escorts**

The contract security provider is expected to provide upon request, to all employees, a personal safety escort, and cash escorts to employees transporting cash on behalf of the organization. Personal Safety and Cash Escorts shall be considered a priority call and shall be responded to in a timely manner. Personal Safety Escorts include providing vehicle escorts.

Visual escorts involve the contract security provider either maintaining a fixed position, or conducting frequent vehicle patrols to monitor foot traffic.

Employees are encouraged to give 15 minute lead time for escort appointments.

### **2.0 Procedure – Personal Safety Escorts:**

4.12.1 Upon notification of a request for escort, the Security Operations Center (SOC) will respond in accordance with the contract security provider's operation procedures.

2.2 The responding staff person will accomplish the following:

2.2.1 Greet the staff person to be escorted.

2.2.2 Confirm the destination of the escort.

2.2.3 Be aware of their surroundings, and remain with the staff person until they are safe in their vehicle or at the destination of the escort.

2.2.4 Conduct a visual check around the vehicle and remain with the person until they have started their vehicle.

### **3.0 Procedure – Cash Deposit Escorts:**

3.1 When hospital staff requests an escort to transport cash, the SOC will dispatch the appropriate staff. The responding staff person will accomplish the following:

3.1.1 Make contact with the requestor at the designated location.

3.1.2 If the employee requests to be escorted from their department to transport cash to the Cashier's Office or other destination, the responding staff person will meet the employee at the department and provide the escort.

3.1.3 If the security representative arrives at the designated meeting area before the employee, the security representative will stand by until the employee's

arrival.

3.1.4 When the employee arrives, the responding staff person will provide the escort.

3.1.5 If necessary, advise the employee to keep the deposit in an inconspicuous place.

3.1.6 The responding staff person shall also determine if the employee will need an escort back to the original location, or to their vehicle.

3.1.7 In the event of a robbery or attempted robbery, the contract security provider will follow their operating procedure.

~~4.1.1~~3.1.8 If the hospital staff has routine cash transport duties, it is recommended that the department shall schedule a regular fixed appointment with the SOC for the routine escorts on a daily or weekly basis.



## **Appendix P: Security Operations Center**

### **1.0 Operation Center Training Checklist:**

- 1.1 Understand the purpose and role of the system operator
- 1.2 Demonstrate the ability to log into the P2000 system
- 1.3 Demonstrate the ability to open the System Tree Functions
- 1.4 Demonstrate the ability to review camera footage
- 1.5 Demonstrate the ability to unlock/lock doors via computer
- 1.6 Demonstrate the ability to export camera footage files
- 1.7 Demonstrate familiarity with reader modes
- 1.8 Demonstrate the ability to search for video files
- 1.9 Identify main alarm monitoring components and options
- 1.10 Identify critical and non-critical alarms, and demonstrate the appropriate response to each
- 1.11 Demonstrate the ability to respond to Aeroscout Alarms and Code Green Protocol
- 1.12 Demonstrate alarm acknowledgement features: Single and Group
- 1.13 Demonstrate the ability to use the Maps Program
- 1.14 Demonstrate use of trace menu: Zone/Device/Badge/Historical/Live
- 1.15 Demonstrate the ability to produce and program an photo ID Badge
- 1.16 Demonstrate the ability to reactivate an inactive access card
- 1.17 Demonstrate the ability to deactivate an access card
- 1.18 Familiarize with the badge replacement policy
- 1.19 Demonstrate the ability to arm/disarm alarm panels

### **2.0 Operations Center Core Competencies:**

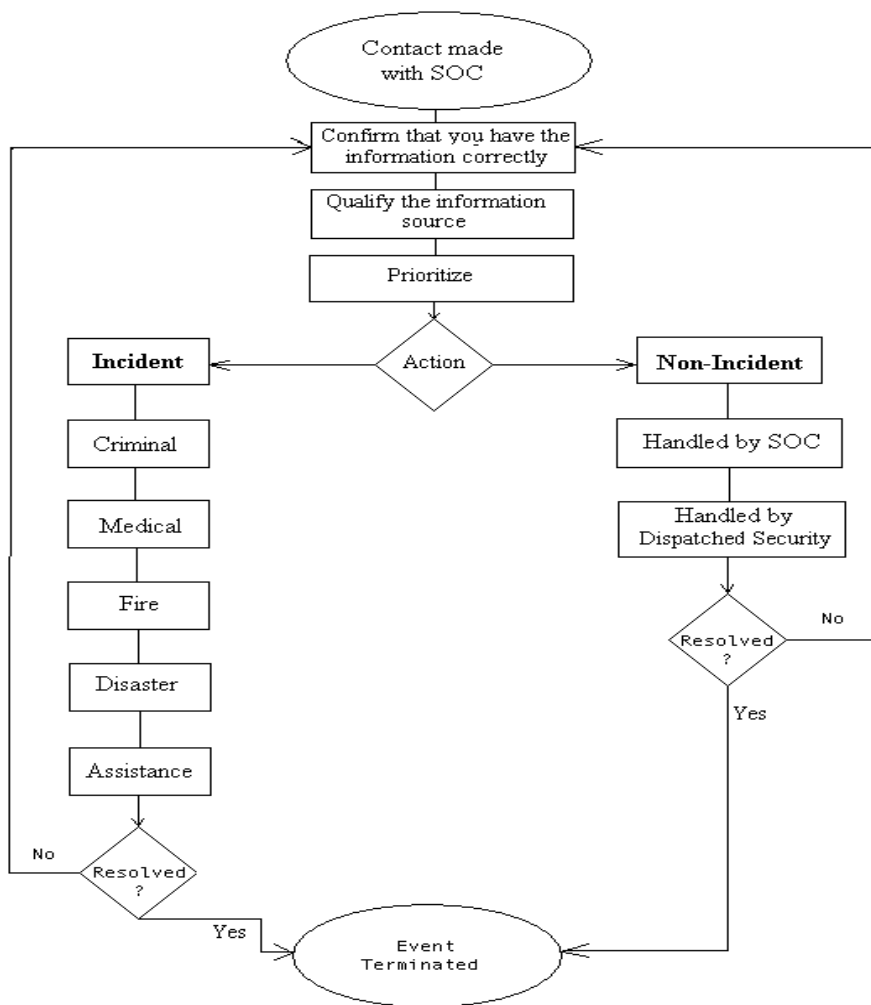
- 2.1 [Building Addresses/Number Identifiers](#)
- 2.2 [Alarm Acknowledgement](#)
- 2.3 [Policy on when to dispatch for alarms](#)
- 2.4 [How to check alarm status](#)
- 2.5 [Logging on and off the P2000 security computer system](#)
- 2.6 [Providing access via P2000 security computer system](#)
- 2.7 [Policy for allowing access via P2000 security computer system](#)
- 2.8 [Turning off Emergency Strobe Lights](#)
- 2.9 [Disconnecting an Emergency Phone](#)
- 2.10 [Aware of all radio codes and positions](#)
- 2.11 [Knowledge of the Federal Communications Commission \(FCC\) call sign](#)
- 2.12 [Officer deployment and responsibilities](#)
- 2.13 [Completing Work Order Form](#)
- 2.14 [Opening and Closing the P2000 security program](#)
- 2.15 [Locating a camera on the P2000 security system](#)
- 2.16 [Placing a camera on the monitor](#)
- 2.17 [Significant Event Notification Procedures](#)
- 2.18 [SOC Malfunction Procedures](#)
- 2.19 [Procedures for Code Red](#)
- 2.20 [Procedures for Internal and External Disaster Involvement](#)
- 2.21 [Procedures for Code Silver](#)
- 2.22 [Procedures for Code Green](#)
- 2.23 [Procedures for Duress-button response](#)

2.24 Procedures for Emergency Response

2.25 Customer Service

2.26 System Rebooting

**3.0 SOC Workflow:**



3.1 All cameras should be "called up" and tested for proper view of intended area as well as quality of picture. Inadequate images should be identified and trouble-shooting should be conducted. Any dysfunctional cameras should be replaced immediately.

3.2 All door contact alarms should be equipped with cameras that monitor the doors with automatic camera call-up and map location of the local sounder is activated.

3.3 All emergency phones, and AeroScout alarm activations should be equipped with cameras which monitor all exciter locations, and upon activation, call-up camera and map of the local exciter is activated.

#### **4.0 SOC System Malfunction Escalation Process:**

During a system malfunction, the SOC Operator will be responsible for the following:

~~2.26~~4.1 Documenting all system failures, including video and alarm systems.

~~2.27~~4.2 Document on the Problem Description Log the following information:

~~2.27.1~~4.2.1 Date of occurrence

~~2.27.2~~4.2.2 Entered by

~~2.27.3~~4.2.3 System Affected

~~2.27.4~~4.2.4 Description of Problem

~~2.27.5~~4.2.5 Steps taken to resolve the problem

~~2.27.6~~4.2.6 Notifications as necessary

4.2.7 Upon inspection by the contract service provider/facilities engineer, require that they enter the date, initials, and comments regarding the system's status

~~2.28~~4.3 Notify the shift supervisor/Watch Commander, and provide the following information:

~~2.28.1~~4.3.1 Description of problem

~~2.28.2~~4.3.2 Steps taken to resolve problem

4.3.3 Update the shift supervisor/Watch Commander of any system status changes.

4.4 The shift supervisor/Watch Commander will contact the contracted service provider and the Facilities Services Department to report the system malfunction.

4.5 Problem Description Log diagram:

<b><u>SURVEILLANCE CAMERAS/VIDEO SYSTEMS/ALARMS/RADIO CONSOLETTTE</u></b> <b><u>PROBLEM DESCRIPTION LOG</u></b>
--

<u>Date</u>	<u>Entered By</u>	<u>System Affected</u>	<u>Description of Problem</u>	<u>Steps Taken to Resolve Problem</u>	<u>Date</u>	<u>Technician</u>	<u>Comment</u>
<u>Enter date of occurrence</u>	<u>Name and Star #</u>	<u>Which video system or systems were affected</u>	<u>Describe the problem in detail</u>	<u>List all steps taken to resolve the problem(s) and all notifications made</u>	<u>Date Siemens responded</u>	<u>Technician's Name</u>	<u>Additional information provided by Siemens Technician</u>

### **5.0 SOC Response to a Non-Emergency Service Call:**

When the contract security provider is required to respond to a non-emergency service call:

- 5.1 The dispatcher/phone operator will give an appropriate greeting, and determine the service needed.
- 5.2 Non-emergency service calls are dispatched in the order of priority according to the contract security provider's operation procedure.
- 5.3 The response time to respond to a non-emergency service call is 5 minutes from the time the SOC receives the service request from the caller.
- 5.4 The dispatcher/phone operator should get the requester's contact information to periodically update them on the status of the security response or any delays to provide service

### **6.0 Security Response to Emergency Call:**

When the contract security provider is required to respond to an emergency service call:

- 6.1 The dispatchers/phone operator will give an appropriate greeting, and determine the security emergency.

2-29.2 To maintain discretion, while getting pertinent information, the security dispatcher/operator will ask appropriate Yes/No questions. For example:

2-29.16.2.1 Is the person in front of you at this time?

2-29.26.2.2 Has the person displayed a weapon?

6.2.3 Has anyone been injured?

6.3 The dispatcher will dispatch contract staff to respond in accordance with the contract security provider's operation procedures.

6.4 Based on the information learned from the caller, the dispatcher/phone operator will communicate the information to the responding contract staff persons.

6.5 When possible, the SOC should notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

6.6 The response time to respond to an emergency incident is 3.5 minutes from the time the SOC receives the emergency call. The dispatcher/phone operator should get the requesters contact information to periodically update them on the status of the security response.

**7.0 Security Response to Duress-Panic Button Activation:**

7.1 When the SOC receives a staff duress-button activation, the security dispatcher should immediately dispatch contract staff to respond in accordance with the contract security provider's operation procedures.

7.2 When a duress-button is activated, location associated with the duress-button will appear on the dispatcher's monitor, including the location of the panic-button activation.

7.3 The dispatcher/phone operator will acknowledge the alarm via computer, and call the phone number for the activated duress-button.

~~2.30~~7.4 To maintain discretion, while getting pertinent information, the security dispatcher/phone operator will ask appropriate Yes/No questions. For example:

~~2.30.1~~7.4.1 Is the person in front of you at this time?

~~2.30.2~~7.4.2 Has the person displayed a weapon?

7.4.3 Has anyone been injured?

7.5 Based on the information learned from the caller, the dispatcher/phone operator will communicate the information to the responding contract staff persons.

7.6 The response time to respond to a duress-button activation is 3.5 minutes from the time the SOC receives the alarm.

**8.0 SOC Response to Civil Disturbance:**

~~2.31~~8.1 SOC will immediately radio the contract provider's shift supervisor, and report the details of the event, including location.

8.2 Dispatch contract staff to respond in accordance with the contract security provider's operation procedures, including accomplishing the following:

~~2.31.1~~8.2.1 Upon hospital leadership approval, remotely lockdown the facility as directed.

~~2.31.2~~8.2.2 Ensure Operator Service's communication to activate the appropriate facility response.

~~2.31.3~~8.2.3 Activate the Significant Incident Notification Procedure.

~~2.31.4~~8.2.4 Monitor CCTV cameras of the affected areas, and report all suspicious incidents to the contract provider's shift supervisor. Complete a supplemental report, describing all suspicious incidents.

8.3 When possible, the SOC should notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

## **9.0 SOC Response to a Bomb Threat:**

~~2.32~~9.1 SOC will immediately radio the contract provider's shift supervisor, and report the details of the event.

~~2.33~~9.2 Dispatch contract staff to respond in accordance with the hospital's Bomb Threat Procedure.

~~2.34~~9.3 SOC will activate the Significant Incident Notification Procedure.

~~2.35~~9.4 The SOC will be the clearinghouse for all information associated with the bomb threat and will keep administrative staff, including the Administrator-On-Duty informed of the status of the bomb threat.

~~2.36~~9.5 Monitor CCTV cameras, and report all suspicious incidents to the contract provider's shift supervisor. Complete a supplemental report, describing all suspicious incidents.

~~2.37~~9.6 As directed, ensure Operator Service's communication to activate the appropriate facility response.

## **10.0 SOC Response when there is no water supply:**

~~2.38~~10.1 Gather all detailed information regarding the incident and activate the Significant Event Notification Procedure.

10.2 As information is received, dispatch contract staff to respond in accordance with the contract security provider's operation procedures.

~~2.39~~10.3 Ensure Operator Services communication to activate the appropriate facility response.

10.4 Contact the Engineering Department, Environmental Services, and the Hospital Command Center as required.

### **11.0 SOC Response to hazards/spills:**

~~2.40~~11.1 If the SOC is called to support a hazardous spill, dispatch the contract security provider's shift supervisor to assess the situation, and determine the appropriate security response, including accomplishing the following:

~~2.40.1~~11.1.1 Prevent anyone from entering the area

11.1.2 Assist with evacuation as directed

~~2.41~~11.2 Activate the Significant Incident Notification Procedure.

~~2.42~~11.3 Ensure Operator Service's communication to activate the appropriate facility response.

~~2.43~~11.4 Notify the Department of Workplace Safety and Emergency Management at 4-3321.

~~2.44~~11.5 Notify the Watch Engineer.

11.6 Upon hospital leadership approval, remotely lockdown the facility as directed.

### **12.0 SOC Response to a power outage**

~~2.45~~12.1 If the SOC is called to support a campus power outage, dispatch the contract security provider's shift supervisor to assess, and determine the appropriate response, including accomplishing the following:

~~2.45.1~~12.1.1 Notify the Engineer Department, if applicable

~~2.45.2~~12.1.2 Receive direction from the Engineering Department and Hospital Command Center if applicable

~~2.45.3~~12.1.3 Prevent anyone from entering the area as directed

~~2.45.4~~12.1.4 Assist with evacuation/escorts as directed



~~2.45.5~~ 12.1.5 Activate the Significant Event Notification Procedure.

~~2.45.6~~ 12.1.6 Upon hospital leadership approval, remotely lockdown the facility as directed

12.1.7 Ensure that the offices are secured in impacted buildings.

~~2.45.7~~ 12.1.8 Limit visitation as directed

12.1.9 Maintain communications with appropriate leaders as directed/appropriate

### **13.0 SOC Response to a person trapped in an elevator**

~~2.46~~ 13.1 If the SOC is called to support a report of a person(s) being trapped in an elevator, determine the elevator location, and building address, and dispatch the contract security provider's shift supervisor to assess, and determine the appropriate response, including accomplishing the following:

~~2.47~~ 13.2 Receive direction from the Engineering Department if applicable

~~2.48~~ 13.3 Provide appropriate information to the responding contract security staff.

~~2.49~~ 13.4 As required ensure that communication is maintained with the person(s) in the elevator determining the following:

~~2.49.1~~ 13.4.1 If anyone is injured

~~2.49.2~~ 13.4.2 If anyone is experiencing any physical illness

~~2.49.3~~ 13.4.3 How many people are in the elevator?

13.4.4 How long has the elevator been inoperable?

13.5 As required, ensure that the fire department and the elevator service company have been notified.

13.6 Maintain communication with appropriate leaders as directed/appropriate

~~2.50~~ 13.7 The response time to respond to an elevator assist is 3 minutes from the time the SOC receives the alarm.

13.8 If the responding contract security provider staff is required to maintain communication with the trapped person(s), encourage them to remain calm, and periodically assess their physical and mental wellbeing until they are freed from the elevator.

13.9 Document the incident including the names of the victims, their witness statements, and contact information of all respondents.

#### **14.0 Missing Resident Response:**

If the SOC is called to respond to a missing resident, obtain “Emergency Notification of Missing Resident” form from Nursing Operations or Nurse Manager (refer to LHHPP 24-22 Code Green Protocol). The form shall include a full description, including name, age, ethnicity, sex, hair color, height, weight, eye color, description of clothing, mental status, and any other pertinent information.

14.1 Dispatch the contract security provider’s shift supervisor to assess, and determine the appropriate response, including accomplishing the following:

~~2.50.1~~ 14.1.1 Activate the Significant Event Notification Procedure.

14.1.2 Maintain communications with appropriate leaders as directed/appropriate.

#### **15.0 Active Shooter Response:**

If the SOC is called to respond to an incident involving an active shooter, refer to LHHPP 70-04 Code Silver for notification and Incident Command procedure.

~~2.51~~ 15.1 Dispatch the contract security provider’s shift supervisor to assess, and determine the appropriate response.

~~2.52~~ 15.2 As directed, communicate with the contract security provider’s chain-of-command for immediate support.

~~2.53~~ 15.3 Activate the Significant Incident Notification Procedure.

~~2.54~~ 15.4 Maintain communications with appropriate leaders as directed/appropriate.

#### **16.0 Operations Center Systems and Processes:**

##### 16.1 P2000 Security System

P2000 is a company which manufactures both hardware and software for the purpose of electronic security. The hardware ranges from the alarm contacts, to switches, to alarm panels which control the signals and communication process. Some panels function independently should something happen to the server or host computer. Other devices must be in constant contact with the host or server in order to function. Alarm signals going directly into P2000 will allow the Operator/Dispatcher to receive, and acknowledge alarm activity.

The system can accumulate data from the field, storing it in a retrievable fashion, and also is capable of combining the badging process with access card control activity.

#### 16.2 Alarms – Structuring, Priorities

Alarm signals should appear in a “coded” format that allows the dispatcher/phone operator, at a glance to make sense of the alarm, in order to take action. The code will indicate the facility, building, and location, and type of alarm i.e. duress alarm, motion detector, intrusion alarm, and AeroScout alarm.

P2000 allows for prioritizing incoming alarms, so that a high priority alarm is not knocked off the viewing screen by a low priority alarm. P2000 makes the lowest priority a lower number and the higher the priority the higher the numbering sequence. Duress alarms, Safe Door alarms, Narcotics Cabinets, etc, are highest levels, while an alarm on an interior door for a storage area would be a (much) lower priority.

P2000 is also an alarm monitoring software, which allows for incorporating camera control into the same “window”. “Wav” files can be attached to categories of alarms, in order to attract the attention of the dispatcher/operator to specific “higher” categories of alarms and conditions.

### 17.0 Releasing Information outside the SOC

The Records Retention and Disclosure Policy address the process for obtaining LHH security records, reports, and video surveillance footage. Except for criminal law enforcement reports, all written and forensic records occurring on LHH premises are the property of Laguna Honda Hospital and Rehabilitation Center.

All requests for information should be forwarded to the Department Information Office, Deputy City Attorney, or DPH Director of Security.

Requests for criminal reports should be addressed to the appropriate law enforcement agency.

### 18.0 Notifications of Events & Incidents

The following is a list of significant events, which if occurring(ed) on the Laguna Honda Hospital, and Trauma Center will require an electronic/phone communication from the contract security provider to the DPH Director of Security:

~~2-55~~ 18.1 Arrest activity involving the use of force

~~2-56~~ 18.2 Robber

~~2-57~~ 18.3 Facility Property Theft (in excess of \$950)

~~2.58~~ 18.4 Sex Offense

~~2.59~~ 18.5 Homicide

~~2.60~~ 18.6 Suicide

~~2.61~~ 18.7 Internal and External Disasters

~~2.61.1~~ 18.7.1 Bomb Threats

~~2.61.2~~ 18.7.2 Fire

~~2.61.3~~ 18.7.3 Natural Disasters

~~2.62~~ 18.8 Significant Law Enforcement activity at the facility that involves use of force

18.9 Significant Media activity at the facility

In addition to the DPH Director of Security, at a minimum, the following should be notified of any significant events:

~~2.63~~ 18.10 Administrator-On-Duty

18.11 Security Provider's Chain of Command

## Appendix Q: Security Response Call Procedures

### 1.0 Purpose

To clearly define the process and expectations of the contract security provider when responding to request for security/law enforcement services.

### 2.0 Non-Emergency Service Calls:

2.1 When the Security Operations Center (SOC) receives a non-emergency service call, the SOC Operator will answer the phone with an appropriate greeting.

2.2 Non-emergency service calls will be dispatched in accordance with the contract security provider's operation procedures.

2.3 The expected response time to respond to a non-emergency service call shall not exceed 10 minutes from the time the SOC receives the service request from the caller. The SOC operator will record the requesters contact information, including name and phone number. In the event of a delay in response, periodic updates will be made to the caller.

### 3.0 Emergency Service Response Calls:

~~1.1~~3.1 The SOC operator will answer the phone with an appropriate greeting.

3.1.1 To maintain the caller's discretion, the SOC operator will advise the caller not to hang-up, and begin gathering pertinent information.

3.2 Based on the information learned from the caller, the SOC operator will dispatch staff to respond to the emergency, providing information regarding the incident.

~~1.2~~3.3 The contract security provider's staff will respond to emergencies in accordance with the contract security provider's operation procedures.

3.3.1 It shall be the responsibility of the contract security provider's leadership to provide oversight, and communicate with hospital leadership, including the Executive Administrator, Administrator-On-Duty, and the DPH Director of Security.

3.4 Security emergencies are expected to be responded to in a timely manner. All non-emergency tasks shall be disrupted, and the responding staff person will explain the need to respond an emergency.

3.5 When possible, the SOC shall notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

3.6 The expected response time to an emergency incident shall not exceed 3.5 minutes.

3.7 Response time begins at the point that the SOC receives the emergency call. The SOC shall get the requesters contact information to periodically update them on the status of the response.

3.8 The responding personnel is expected to maintain safety when responding to security emergencies. Where necessary, responding staff shall call the elevators to their location, and announce to passengers, the need to respond to a security emergency.

#### **4.0 Response to Duress Button Activations:**

4.1 When the SOC receives a duress-button activation, the operator will respond in accordance with the contract security provider's operation procedures.

~~4.3.4.2~~ 4.2 The SOC operator will contact the department to confirm receipt of the alarm, and gather additional information to provide to the responding staff.

4.3 In addition to radioing staff, the SOC operator will acknowledge the alarm via computer, and document the alarm in the appropriate log, in accordance with the contract security provider's dispatch procedures.

4.4 The assigned staff that are dispatched to a duress alarm activation are expected to respond immediately. All non-emergency tasks shall be disrupted, and responding staff person will explain to the caller the need to respond to an emergency.

4.5 The expected response time to a duress-button activation shall not exceed 3.5 minutes.

4.6 The responding personnel are expected to maintain safety in responding to a duress-button activation. When necessary, responding staff shall call the elevators to their location, and announce to the passengers the need to respond to a security emergency.

4.7 Immediately upon conclusion of the duress-button incident, the responding staff will reset the alarm, and ensure that the SOC has a reset reading before leaving the scene.

#### **5.0 Bomb Threat Response:**

5.1 Hospital staff are trained to respond to a bomb threat as follows:

~~4.3.1~~ 5.1.1 Remain calm and listen carefully to language, background noises

and other details.

~~4.3.2~~ 5.1.2 Obtain as much information as possible and write out the exact words used by the caller.

~~4.3.3~~ 5.1.3 Listen very carefully to the caller, obtain as much information as possible, and record the information.

~~4.3.4~~ 5.1.4 Interrupt only to ask:

~~4.3.4.1~~ 5.1.4.1 When is the bomb going to explode?

~~4.3.4.2~~ 5.1.4.2 Where is the bomb right now?

~~4.3.4.3~~ 5.1.4.3 What kind of bomb is it?

~~4.3.4.4~~ 5.1.4.4 What does it look like?

~~4.3.4.5~~ 5.1.4.5 Why did you place it?

~~4.4~~ 5.2 Notification Process:

Any person receiving a bomb threat will notify the SOC from either the external emergency phone number or the internal emergency extension number.

~~4.4.1~~ 5.2.1 The SOC will respond in accordance to the contract security provider's operation procedures, including activating the Significant Event Notification Procedure.

5.2.2 The SOC will be the clearinghouse for all information associated with the bomb threat and will keep administrative staff, including the AOD, informed of the status of the bomb threat.

~~4.4.1.1~~ 5.2.2.1 Knowledge of the existence of a bomb is to be restricted to those individuals who have a need to know in order to prevent general overreaction and panic.

~~4.5~~ 5.3 Bomb Search Evacuation Process:

The contract security provider will follow the bomb threat process and evacuate, according to LHH Bomb Threat Procedure.

## ~~2.0~~ **6.0 Fire Response (Code Red):**

During a Code Red, the contract security provider will respond according to LHH Code Red (Fire) Procedure.

## 6.1 Key Points during a Code Red:

2.1.16.1.1 A decision to evacuate shall come from the Hospital Incident Command System of SFFD.

2.1.26.1.2 The contract security provider will receive all direction from the Facilities Department.

2.1.36.1.3 In hospital neighborhoods/care units, patients may be evacuated horizontally (from a danger area to a safe area on the same floor).

6.1.4 People are allowed to re-enter the evacuated area when SFFD informs the hospital (or Facilities Department) "all clear".

## 7.0 Cardiac and Respiratory Arrest Response (Code Blue):

When called to address a security related issue surrounding a Code Blue (Cardiac/Respiratory Arrest), the role of the contract security supplier's staff will be to provide the following:

7.1 Respond to the scene of the Code Blue and assume crowd control duties, including any person(s) interfering with the code response team, while providing treatment to the patient.

7.2 While using tact and showing compassion, direct visitors and family members away from the scene.

7.3 The contract security provider will maintain their position until cleared by the Code Blue Team Leader

7.4 Document the response on a Daily Activity Report, and Security Incident Report

## 8.0 Civil Disturbance Response:

The likelihood of a civil disturbance may be precipitated by social, political and weapons victim related tensions. Civil disturbances range from relatively small incidents that affect only one area to large scale riots that affect the entire city, state or nation. The impact on Laguna Honda Hospital and Rehabilitation Center will be the treatment of casualties and the implementation of security measures, including increasing security presence to address crowd control, and locking down the facility to mitigate risk to staff, visitors and patients from civil disturbance activity.

In accordance with the LHH Shelter in Place Policy for security emergencies, the purpose of this policy is to protect the health and welfare of all occupants within the hospital and surrounding offices during a civil disturbance incident.



8.1 During a Civil Disturbance the SOC will be expected to respond in accordance with the contract security provider's operation procedure, including accomplishing the following:

~~2.1.4~~8.1.1 Utilize video surveillance, monitoring all exterior entrances and exits.

~~2.1.5~~8.1.2 Ensure that the Executive Administrator has been notified.

~~2.1.6~~8.1.3 Ensure that the Administrator-On-Duty (AOD) has been notified.

~~2.1.7~~8.1.4 Activate the Significant Event Notification Procedure.

~~2.2~~8.2 The contract security provider's staff will respond to the civil disturbance according to their operation procedure, including providing protection to sensitive utilities/areas to prevent tampering or damage to these services:

~~2.2.1~~8.2.1 Central Plant

~~2.2.2~~8.2.2 Main Gas Feed

~~2.2.3~~8.2.3 Sprinkler System Pumps and Valves

~~2.2.4~~8.2.4 Liquid Oxygen Tanks

8.2.5 Hazardous Waste Storage Areas

8.2.6 IT Server Rooms

8.3 If the situations warrants, the contract security provider will provide protection to facility employees that are required to secure glass entrances with plywood to deter vandalism, protect property and secure the entrances.

## **9.0 Hazardous Material Incident Response:**

In the event the contract security provider is contacted to respond to an incident involving hazardous material, refer to the Hospital Policy Spill Response Plan.

## **10.0 Missing At Risk Patient/Resident Response:**

In the event the contract security provider is contacted to respond to an incident involving an At Risk Patient/Resident, the following shall be accomplished in accordance with LHH Code Green Procedure:

10.1 Upon obtaining a full description of the patient, the contract security provider's shift supervisor will deploy contract security provider staff to designated locations to establish a perimeter and begin the search for the missing patient, according

to their operation procedure.

10.2 If the patient is found by the contract security provider, the contract security staff will return the patient to the unit for an evaluation by the primary-care team.

~~2.3~~10.3 If necessary notify via telephone or radio to the following:

~~2.3.1~~10.3.1 San Francisco Police Department

~~2.3.2~~10.3.2 MUNI

10.3.3 BART

## **11.0 Active Shooter Response:**

In the event the contract security provider is contacted to respond to an incident involving an active shooter, the following shall be accomplished in accordance with LHH Code Silver Procedure.

Upon receiving pertinent information, in accordance with the contract security provider's operation procedure, the contract security provider will accomplish the following:

~~2.4~~11.1 Communicate with the contract security provider's chain-of-command for immediate support.

~~2.5~~11.2 Respond immediately.

~~2.6~~11.3 Initiate the Internal and External Disaster Response Procedure, including accomplishing the following:

11.3.1 Depending on the circumstances of the event, law enforcement services in conjunction with local law enforcement will establish a security zone around the hospital perimeter, perform crowd control, and traffic control on public streets, and establish security check points to control access to the hospital campus.

~~2.6.1~~11.3.2 Shall the responding City law enforcement agency initiate its Incident Command structure, then the contract provider staff and law enforcement staff shall be part of the a Unified Command structure. The Unified Command enables coordination of tasks and resources among the various entities.

## **Appendix R: Significant Security Event Notification**

### **1.0 Purpose Statement:**

The purpose of the Security Significant Event Notification Procedure is to define significant security events, and describe procedures for escalation and reporting of the event(s).

### **1.0 Significant Security Events:**

2.1 The following is a list of significant security events, which if occurring(ed) on the Laguna Honda Hospital and Rehabilitation Center Campus will require an electronic/phone communication from the contract security provider to the DPH Director of Security:

1.1.1 Arrest activity involving the use of force

2.1.2 Robbery

1.1.2 Facility Property Theft (in excess of \$1,000)

1.1.3 Sex Offense

1.1.4 Homicide

1.1.5 Suicide

1.1.6 Internal and External Disasters

2.1.7.1 Bomb Threats

2.1.7.2 Fire

2.1.7.3 Natural Disasters

1.1.7 Significant law enforcement activity at the facility that involves use of force

1.1.8 Significant media activity at the facility

### **3.0 Significant Security Event Notification:**

3.1 Upon experiencing a significant security event, the contract security provider will be responsible for notifying at a minimum, the following:

3.1.1 Administrator-On-Duty

3.1.2 Security Provider's Chain of Command

3.1.3 Executive Administrator

3.1.4 DPH Director of Security

3.2 As additional information regarding the event becomes available, follow-up notifications will be made available to those listed in section 3.1.1-4.

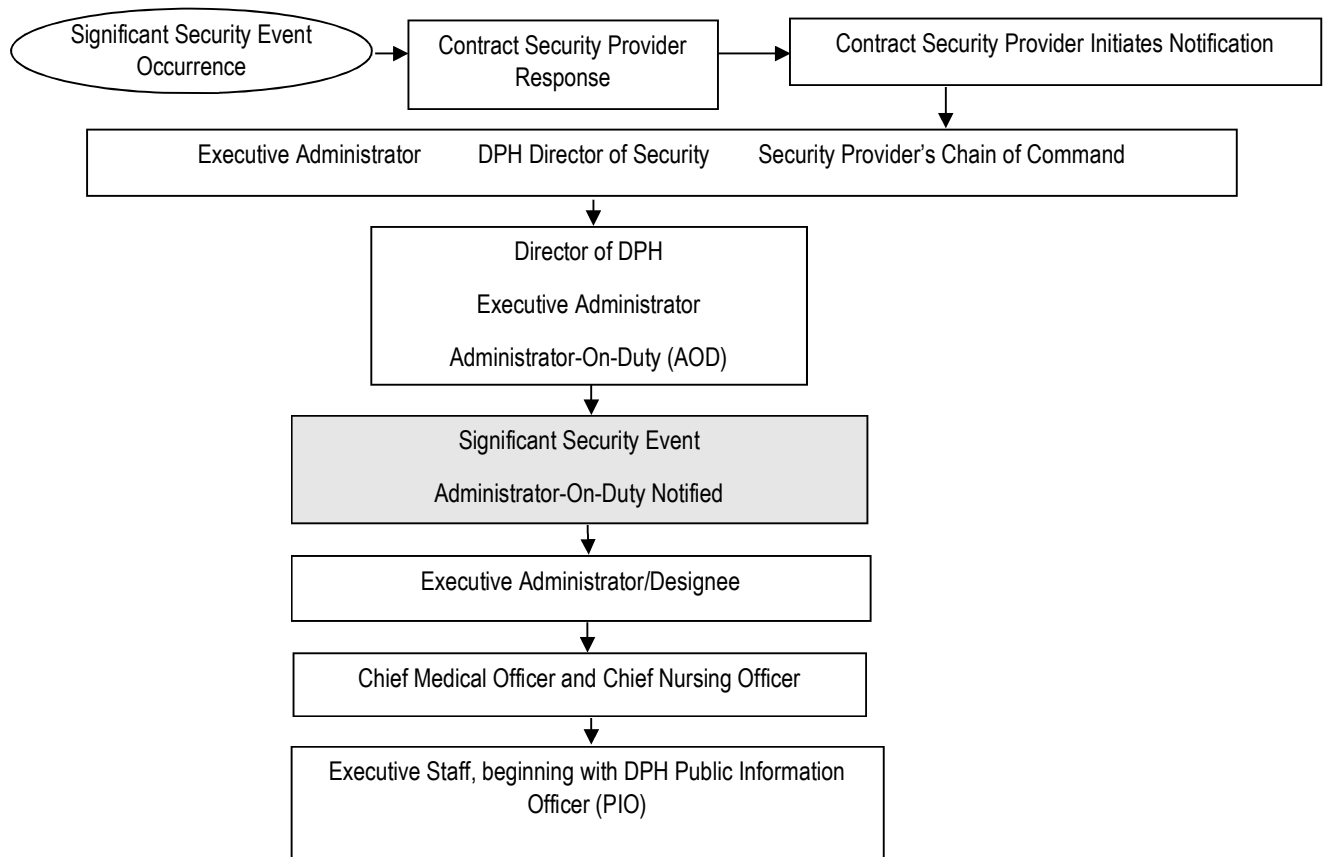
3.3 The DPH Director of Security in conjunction with the following will coordinate the appropriate response plan:

3.3.1 Executive Administrator

3.3.3 Chief Operating Officer

3.3.4 Administrator-On-Duty

**4.0 Significant Security Event Notification Workflow:**



## **Appendix S: Victims of Violent Crime Protection Plan**

### **1.0 Purpose**

The scope is to establish guidelines for a patient/resident that requires special arrangements for protection due to threatening circumstances.

### **2.0 Procedure**

To aid in managing the protection of a patient/resident who requires security protection. Visitors will be screened against the authorized visitors list, as provided by the patient/resident.

2.1 The contract security provider's shift supervisor will receive information regarding any patient/resident that requires security protection.

2.2 It is acknowledged that during off hours, or as the situation demands, the AOD speaks with the authority of the Executive Administrator in their absence. When operational and security demands warrant, the AOD has the power to authorize additional deployment of contract security provider personnel. The AOD will convey such need to the contract security provider's shift supervisor.

2.3 The appropriate medical/nursing staff, and the contract security provider will gather from city law enforcement, information regarding the level of the threat, and the potential impact on the hospital with regard to any attempt of violence against the patient/resident.

2.4 City law enforcement measures may include assigning a police officer outside the patient's/resident's room.

2.5 The contract security provider's staff will conduct frequent patrols on the unit, including addressing large crowds forming on the unit.

### **3.0 Patient/Resident Protection Visiting Process**

Authorized visitors will be limited to immediate family members or surrogate decision maker, and those visitors approved by the patient/resident. All other visitors will be denied access in accordance with the LHH Visiting Policy.

~~4.1.3.1~~ Information regarding the patient will be provided by the appropriate nursing/medical staff only to the next of kin approved by the patient/resident.

~~4.1.13.1.1~~ Media inquiries regarding the patient will be addressed by the Public Information Officer.

~~4.1.23.1.2~~ All other inquiries regarding the patient/resident will be addressed by

the neighborhood's nurse manager or designee.

## RESIDENT ACTIVITIES OF DAILY LIVING (~~Basic Care~~)

### POLICY:

1. ~~Licensed Registered~~ Nurse assesses the functional ability of each resident ~~to perform the activities of daily living (ADL) meet the demands of daily living~~ upon admission, quarterly, annually and when a significant change in condition occurs.
2. The Licensed Nurse in collaboration with the RCT develops a plan of care to meet the resident's ~~plans a program of assistance and instruction in Activities of Daily Living (ADL)~~ needs, while promoting as much functional independence as possible~~skills for each resident.~~
3. All nursing staff except Home Health Aides may be assigned to provide assistance with ADL care. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

~~Residents are to be educated to be taught and encouraged to be as independent as possible with ADL. The exception would be residents with progressive illness or those at the end of life, when increased functional dependency is expected.~~

~~Nursing Caregivers which includes Certified Nursing Assistant (CNA) and Patient Care Assistant (PCA), may be assigned to provide resident comfort and hygiene.~~

- ~~3. Unless more specialized precautions are warranted Each nursing staff member is to use appropriate infection control precautions such as hand washing, changing disposable gloves, and changing plastic aprons when soiled in between residents.~~
- ~~4. Residents with indwelling catheters are to receive catheter care every shift by assigned CNA or PCA.~~
4. Each resident's personal hygiene supplies are to be labeled with resident's initials and bed room/number and kept ~~in~~ by the resident's bedside.
5. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

### PURPOSE:

- ~~To meet the basic needs of comfort and hygiene~~  
1. ~~To cleanse and refresh the resident and adjust the level of nursing intervention. To~~ promote resident comfort and hygiene.
- ~~1.2.~~ A program of ADLs is provided to residents to prevent disability and return resident to a maximum level of independence.

---

### PROCEDURE:

#### ~~A. Equipment~~

- ~~1. Obtain from unit's linen room: clean linen, linen hamper, gloves, and apron~~
- ~~2. Obtain from resident's bedside: personal supplies or items (including, but not limited to: wash~~

**Resident Activities of Daily Living (~~Basic Care~~)**  
*Nursing Policies and Procedures*

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~~basin, soap, lotion, oral hygiene equipment, shaving supplies, comb/brush, clothing, bed pan, urinals).~~

- A. Preparation of Resident** – The resident's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's dignity, privacy, safety and confidentiality.
1. ~~Gather all anticipated hygiene and grooming supplies before approaching to the resident. Sensitivity to resident's feelings related to increased dependency is expected of all caregivers.~~
  2. ~~Knock before entering the room and introduce~~ Announce yourself to the resident ~~/ask permission to enter the resident's room or area.~~
  3. Explain care activities to the resident and enlist their cooperation.
  4. ~~Screen for~~ Maintain privacy during care and ~~and take care not to expose the resident unnecessarily. k~~ Keep the resident warm and covered as much as possible during care.
  5. Engage the resident in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aides as needed.
  6. The individualized resident care plan is followed by all nursing staff, and updated as needed.

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~~Continue next week 08.14.15~~

- ~~A.~~ **BC. Activities of Daily Living** – Activities of daily living are those needed for self-care: bathing, dressing, mobility, toileting, eating, and transferring. Basic nursing care procedures are to be followed utilizing Mosby's  
—Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.

**1. Hygiene & Grooming** Personal Hygiene

- a. Individualized restorative nursing programs for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident's abilities.
- b. Resident is positioned at the sink or bedside with all necessary equipment within reach.
- ~~c. Equipment and instruction provided for to mouth care, bathing, shaving, makeup, and hair care are provided.~~
- c. maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
- d. Skin care routinely includes teaching and assisting the resident to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.
  - ~~i. A washbasin of water that is kept clear from beginning to end of the bathing procedure may be utilized to eliminate trips to the sink to change the water. Several clean washcloths are provided: 1 cloth is used for soaping, one for rinsing, and 2 or more for perineal cleansing.~~
  - ~~ii. Once a washcloth has soap on it, it is not returned to the basin but may be remoistened with water taken from the basin in a cupped hand.~~
  - ~~iii. Fresh washcloths are used for the perineal area.~~
  - ~~iv. Care is taken to rinse well with clear water. If the water inadvertently becomes soapy, it must be replaced.~~



## 2. Dressing

- a. Residents are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
- ~~a-b.~~ Residents are encouraged to choose their clothing.
- ~~b-c.~~ Adaptive equipment is provided and used as needed.
- ~~c-d.~~ Alternative methods of dressing are taught as needed.
- ~~d-e.~~ Occupational therapy consultation is requested as needed through the primary physician.

## 3. Eating

- a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
- b. Residents are encouraged to eat preferably in the dining room.
- c. Residents are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
- d. Specialized feeding plans, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
- e. Dentures and adaptive devices are provided and utilized as needed.
- f. Oral care after each meal is strongly encouraged. When residents do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

## 4. ~~Elimination~~ Toilet Use

- a. Cognizant residents are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing Caregiver may reinforce this information within their scope of practice and related policies.
- b. Privacy and comfort during elimination must be maintained.
- c. When placing resident on the toilet or commode, the employee is to ensure resident safety until resident is ready to leave, then assist resident to stand and walk or transfer as needed.
- d. Incontinent residents are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.
- e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.
- f. Residents with indwelling urinary catheters receive perineal care each shift and as needed.

## 5. Transfer, Ambulation ~~, and Range of Motion~~

- a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing.
- b. Follow basic safety principles for transfer and ambulation such as coaching the resident to rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.

- c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the front card of the care plan and is to be followed.

#### 6. Bed Mobility

- a. Nursing standards for every two-hour turning/ repositioning of dependent residents are to be followed.
- b. Exceptions to the above-noted standard related to resident preferences not to be disturbed during hours of sleep are to be discussed with the Interdisciplinary Team (IDT) Resident Care Team (RCT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.
- c. Resident may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident has limited weight bearing status.

#### C. Organization of ~~r~~Resident ~~e~~Care ~~a~~Assignments

1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.
2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents on the neighborhood to let each resident know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.
  - a. Rounds are to include the resident's rooms, bathrooms, and other areas on the neighborhood where residents are residing.
  - b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.
  - c. To ensure safety, reassure dependent residents to request for assistance to move or get up.
  - d. Before beginning a lengthy procedure with a resident, it is usually appropriate to check on the other residents first to promote regular monitoring of residents.
3. **Time preferences:** ~~Most residents prefer to be bathed in the morning, however the time of day the resident prefers care to be given is to be respected.~~ Check in with residents for preference of bathing time. Refusals of care or resident requests that place an undo burden on the staff are negotiated to achieve a reasonable compromise with IDT-RCT members' support as needed.

#### D. Environment of Care

1. **Personal supplies** are labeled with permanent ink marker pen with resident's initials. Personal supplies or items may include, but not limited to, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, electric shavers, bedpans and urinals.
  - a. Each personal supplies or items such as oral hygiene equipment, washbasins, and adaptive eating utensils are rinsed after each use, allowed to air dry and returned to resident's bedside stand.
  - b. Clean urinal, bedpan, and bedside commode with **facility-approved disinfectant.**
  - c. Clean bedpans or urinals are kept in the lower drawer of bedside cabinet. If resident prefers, clean urinals may be kept within reach of resident.
  - d. Oral hygiene equipment, bedpans or urinals are changed as needed.

**Resident Activities of Daily Living (~~Basic Care~~)**  
*Nursing Policies and Procedures*

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2. **Combs and brushes** are to have hair removed and are to be cleaned ~~with hospital-approved disinfectant~~ as needed and replaced when broken or worn.
3. **Resident's area** is to be kept orderly and clean including:
  - a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
  - b. Spills or unclean floors are brought to the attention of EVS staff.
  - c. Resident preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents unnecessarily, for example:
    - i. Provide containers for non-perishable food.
    - ii. Offer regular snacks and provide a realistic means for able residents to obtain nutritious snacks independently.
    - iii. Offer assistance in tidying up with the resident-/family/responsible party.
    - iv. Offer assistance in prioritizing items if resident feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.
    - v. Communicate regularly with residents regarding which items they value so that items are not inadvertently discarded as trash.
    - vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are **not** ~~permissible~~ permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents / Visitors.)
4. Resident's **personal clothing** is laundered in the neighborhood or on site. See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.
5. **Linen** and other **personal care items** are not to be brought to another resident's area once such items are brought into a resident's room.
  - a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
  - b. The soiled linen hamper is to be covered at all times and is to be emptied before it is more than  $\frac{3}{4}$  full or when it is malodorous.
  - c. Linens carts are distributed to each neighborhood by laundry staff once a day. Staff is to gather supplies needed for each resident prior to beginning care.
  - d. Gather supplies needed for each resident prior to beginning care.

### E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.
2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents.
3. IADL programming that specifically supports resident comfort and hygiene and may be provided in whole or in part by nursing may include:
  - a. Manicures
  - b. Make-up application
  - c. Walking, including walk to dine programs
  - d. Exercise programs
  - e. Practice folding garments or linen
  - f. Grooming activities
  - g. Off neighborhood visits, strolls, and activities

### F. Reporting and/or Documentation

1. **Daily Nursing Care Record (DNCR)**  
CNA or PCA: Record level of function for each ADL as indicated on the DNCR form. Report any physical or behavioral changes to the charge nurse and document in the narrative notes section of the DNCR.
2. **Progress Notes**  
Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident ADLs and DNCR entries and document resident status on the monthly/weekly summary, as directed by the Documentation policy.
3. **~~Graphic Records / Intake and Output Records~~**  
Record and report as per related policies.

### ATTACHMENTS/APPENDICES:

None

### REFERENCES:

Sorrentino & Remmert, Mosby's Textbook for Nursing Assistants, 68<sup>th</sup> edition, 201204

### CROSS REFERENCES:

Hospitalwide Policy and Procedure  
22-03 Resident Rights

Nursing Policy and Procedure  
B 5.0 Color Codes –Resident Identification  
~~Nursing Policy and Procedure B 10.0 Resident Rights~~

**Resident Activities of Daily Living (~~Basic Care~~)** \_\_\_\_\_  
*Nursing Policies and Procedures*

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~~Nursing Policy and Procedure C 3.0 Documentation of Resident Care~~ Status by the Licensed Nurse

~~Nursing Policy and Procedure C 3.2 Documentation of Resident Care by Certified Nurse Assistants or~~

\_\_\_\_\_ ~~Patient Care Assistants~~ Nursing Assistant

~~Nursing Policy and Procedure E 1.0 Oral Management of Nutritional Needs~~

~~Nursing Policy and Procedure Section~~ Section F: Elimination Procedures

Facility Services Policy and Procedure

EM-6 Laundry Equipment Repairs and Clean Up

Document revised: 12/2005; 01/2006; 09/2009; 04/2010; 03/2016

Document reviewed: 4/2010

## NURSE AND RESIDENT CALL SYSTEM

### POLICY:

1. ~~No staff, except Clinical Informatics or Informational Technology~~ Prior authorization is required from administration, should to turn off the System or change any settings that decrease the volume as it can impact resident safety.
2. Resident assignments shall be entered by charge nurse or designee.
2. Residents with limited hand mobility, aphasia, and/or hard of hearing will be evaluated by a licensed nurse using adaptive devices guidelines for the correct adaptive device. Complex situations will be referred to appropriate rehabilitation staff for evaluation.
- ~~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.~~
- ~~2.3. All Licensed Nurses (LNs), Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) will be assigned a SpectraLink® phones with~~ corresponding to resident assignments.
4. Unit clerks can answer the routine calls and forward the call/request to the assigned nursing staff.
- ~~3.5. 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. 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 by going to that location. Unit clerks can answer the routine calls and may send forward the call and specific requests to the assigned nursing staff.~~
6. Any call where the listener is unable to determine the resident's need requires the responder to physically go to the resident/location.
- ~~4.7. Designated HHA may answer/respond to routine calls, bed exit alarms, and bath calls as requested by the LN and within the scope of HHA responsibilities.~~
- ~~5.8. All resident information on the Master Call Station is confidential. Any changes or updates regarding resident information in the Master Call Station can be made only by an authorized staff member. Nursing staff shall not turn off the System or decrease the volume as it can impact resident safety.~~
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.~~
9. All resident bedside call lights must be checked weekly daily, and shower and bathroom call lights must be check weekly for proper function.
- ~~7. during bedside stripping as scheduled by the nurse manager and/or charge nurse.~~

### PURPOSE:

**Nurse and Resident Call System**

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To be able to communicate with residents and staff in order to meet the resident's need in a timely and prompt manner.

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**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**

	<b>Light Illumination Patterns</b>
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**Nurse and Resident Call System**

<b>Types of Calls</b>	<b>Dome light</b>	<b>Zone light</b>
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
  - ~~a.b. Weekly on bed stripping days for shower and bathroom call lights.~~

## ~~3.4.~~ 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 if 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 \_\_\_\_\_

## ATTACHMENT 5 – Shower Tilt Chairs (Combi Tilt Chairs) (~~Shower Tilt Chairs~~)

### A. Background

The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility. The Combi Tilt Chair can be used as a shower chair, commode, and as a transport chair for indoor transportation.

### A.B. Operating Guidelines

1. As part of orientation, ~~the competency of~~ all bedside nursing staff will be trained on how to effectively use the shower chair commode and will be reviewed as needed is validated; and annually thereafter as part of their performance appraisal.
- ~~1. The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility. The Combi Chair can be used as a shower chair, commode, and as a transport chair for indoor transportation.~~
2. Prior to a resident's use of the shower chair commode, nursing staff must assess and ensure that the resident fits the following criteria in order to provide resident safety:-
  - a. Weight does not exceed 150kg/330lbs.;
  - b. Resident is unable to sit securely in an upright position and can be transported more securely with the chair in a tilted position-
  - ~~c. Has good trunk control and does not lean sideways or forward,~~
  - ~~d. Does not exhibit involuntary movements,~~
  - ~~e.c. Is not restless and is able to follow directions,~~
  - ~~f. Resident care plan states that the resident prefers and may use the shower chair commode for bathing.~~

### B.C. Operating Shower Chair Commode

1. Lock all four castors ~~B~~before using the tilting function of the chair, ~~lock all four castors.~~
2. Check the snaplocks frequently and ensure that they are inserted correctly into the tubing.
3. Tilt the chair by ~~means of gas piston activated via~~activating the hand lever on the push bar (behind the backrest).
4. ~~When hand lever is activated, use the push bar to c~~Control the backward and forward tilting movement of the chair (rear operations) by using the push bar when the hand lever is activated.
5. When tilting the chair forward, place one hand on the push bar and the other hand on the seat surface (side operation).
6. The headrest's height, and angle are laterally adjustable by loosening the hand levers. The levers must be tightened securely afterwards.

7. Avoid placing fingers/hands underneath the armrests as it might cause a risk of squeezing fingers/hands (when the armrests are folded up). The armrest can be lifted when transferring patient to the chair.
8. Anti-skid padded seat must be secured when using the chair.
9. Ensure that the seatbelts are ~~snapped-locked~~ snap locked for resident's safety; seatbelts are adjustable to fit the resident needs.
10. Never tilt the chair without the backrest in place
11. When transferring a resident, adjust the height of the chair.
12. Lock the wheels when the Ceombi Tilt eChair is not being used for transportation

#### **C.D. Cleaning and Disinfecting of Shower Chair Commode**

1. The Ceombi Tilt eChair must be cleaned after each use with the facility approved nonabrasive or non-corrosive surface cleaner.
2. The chair can be washed up to 85 degrees centigrade for 3 minutes.

#### **D.E. Maintenance**

1. Check the gas piston's cable regularly to verify that it has the correct tension.
2. CNA/PCA/HHA to inform licensed nurse if the Ceombi Tilt Chair is broken. Do not use broken chairs. Tag and remove broken chairs from circulation.
3. Licensed Nurse will call Plant Services for any repair or services as needed.
4. The Licensed Nurse may also submit a "work order web request" by clicking "Plant Services Work Request" on the Laguna Honda Intranet. An email alert will be sent on change of status.

#### **REFERENCES:**

[Handicare. \(2016\). A mobile and height-adjustable, tilting commode/shower chair available in two variants.](#)

Approved: 05/12/2015

## LIMB CARE FOLLOWING AMPUTATION (~~formerly referred as Stump Care~~)

### POLICYIES:

1. The Licensed Nurse (LN), Certified Nursing Assistant (CNA), or Patient Care assistant (PCA) may perform and/or assist residents with limb care.
2. Registered nurses are responsible for assessments of residents with recent amputations.
3. ~~Licensed Nurses~~ The LN is ~~are~~ responsible for resident education when indicated.

### PURPOSE:

To ~~maintain the health of the residual limb~~ prevent complications after a ~~lower~~ an extremity amputation and to optimize prosthetic fit ~~in the residual limb when indicated.~~

### DEFINITION:

~~Recent amputation pertains to residents who have undergone an amputation and who have actively healing surgical sites and/or are in the process of prosthetic fit.~~

### PROCEDURES:

#### A. Care of the Residual Limb following a recent amputation

1. Lower Extremity Amputations
  - a. Positioning
    - i. For transtibial (~~aka: BKA: below the knee~~) amputations, when seated, have resident/patient avoid dangling or hanging limb. If ordered, use an "amputee board" or "stump protector" to position the residual limb in extension at the knee. These devices are not necessary for amputations at or proximal to the knee.
    - ii. ~~Encourage the resident/patient to move the residual limb to prevent stiffness, spasms, contractures, skin breakdown, and thromboembolism.~~
    - iii. ~~If resident/patient unable to reposition self, turn and reposition the resident/patient resident regularly to prevent spasms.~~
    - ~~ii.iv. Turn and reposition the resident/patient every 2 hours side to side to prevent spasms. If ordered, and the resident/patient can tolerate it, tTurn the resident/patient resident/client prone Encourage resident to lie prone as tolerated for 15-20 minutes every day 3-4 times per day to a prone position to help prevent contractures in lower extremity amputations per physicians order and as tolerated.~~  
~~—Encourage the resident/patient to move the residual limb to prevent stiffness, spasms, contractures, skin breakdown, and thromboembolism.~~
    - iii.v. For transtibial amputations, keep the knee straight.
    - iv.vi. ~~For all lower extremity amputations with~~ If a residual limb present, avoid propping the limb on pillows when the resident is lying or sitting. ~~keep the limb flat and extended.~~

## Limb Care Following Amputation

4, 2014 February, 2016, Revised

(formerly referred as Stump Care)

LHH Nursing Policies and Procedures

- File: D5 2.0 May 13, 2011 April

- b. ~~Prior to the sutures being removed, the limb may be covered by a cast or a residual limb shrinker stocking~~ Residual limb shrinker sock use
  - i. ~~Follow the physician's orders for dressing changes.~~ Don the shrinker sock (see Appendix A).
  - ii. The patient is to wear the shrinker sock at all times except for twice daily skin checks and bathing.
  - iii. Keep the shrinker sock clean.
    - i. Wash the shrinker sock by hand and let air dry
  - iv. Ensure that each patient has 2 socks (one to wear and one to wash)

i. —

### 2. Upper Extremity Amputations

- a. Muscle stretching and strengthening
  - i. Follow exercises as ordered or recommended by a rehabilitation specialist.
  - ii. Educate and encourage the resident/patient resident to perform these exercises independently if appropriate.
- b. Touch and Desensitization
  - i. Follow the physician's orders and rehabilitation therapists' recommendations regarding gentle massage, tapping and rubbing to the residual limb in preparing the limb for prosthesis.
- c. Residual limb shaping
  - i. To manage swelling and prepare the residual for prosthetic fit, a residual limb stocking (~~aka:~~ "stump" shrinker or compression stocking) may be obtained from orthotics clinic.
  - ii. The stocking is washed regularly and when soiled daily with soap and water and must be thoroughly dried before being applied to the limb.
  - iii. Stockings should be used daily unless otherwise specified.
  - iv. If a ~~healing~~ wound is present, skin should be checked q shift.

3. DO NOT ~~elevate or prop up~~ ~~place pillow under~~ knee or hip ~~beyond~~ after 48 hours post-op.

### B. Daily care of the residual limb

1. Examine the limb daily after the prosthesis is removed for redness, swelling and impaired skin integrity.
2. Assist the resident/patient ~~resident to wash~~ with washing the residual limb ~~daily in the evening~~ with warm water and mild soap.
3. Rinse and dry thoroughly.
4. While limb is in the process of shrinking for prosthesis fit, ~~Do not~~ apply moisturizers and do not shave the limb.
5. Unless otherwise ordered, stump shrinker stockings should be ~~cleaned and~~ worn daily for comfort and skin protection.

### C. Care of Prosthesis

**Limb Care Following Amputation**

- File: D5 2.0 ~~May 13, 2011~~ April

~~4, 2014~~ February, 2016, Revised  
~~(formerly referred as Stump Care)~~  
LHH Nursing Policies and Procedures

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1. Clean the interior socket daily with mild soap and water ~~on~~ using a soft cloth. Leave to dry overnight.

**D. Reporting and/or Documentation:**

1. In the DNCR, the CNA or PCA will document any redness, abrasions, blisters, boils or edema. Report any skin changes to licensed nurse LN in charge of resident/patient ~~resident~~.
2. In Interdisciplinary Progress Notes/Acute Nursing Flow Sheet-, the licensed nurse LN -will document assessment and report any changes to physician.

**REFERENCES:**

Appendix A: Donning the Shrinker Sock

Jacelon, C.S. (2011). The specialty practice of rehabilitation nursing. A core curriculum. Sixth edition.

Nettina, S., The Lippincott Manual of Nursing Practices, 9<sup>th</sup> edition, 2010  
Sorrentino, Mosby's Textbook for Nursing Assistants, 6<sup>th</sup> edition, 2004

**CROSS-REFERENCE:**

Nursing P&P D01.0 Restorative Nursing Program

Revised: 8/2000, 2/2010, 04/25/2011, 4/2014

Reviewed: \_\_\_\_\_

For the use only: Date sent to Policy Reviewer _____ <u>03/28/14</u> Date received from Policy Reviewer _____ Date reviewed by NEC _____ Date approved by NEC _____ Date routed to MEC _____ Date emailed to Karina _____
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## Donning the Shrinker Sock



- Pull the shrinker up the residual limb until the plastic ring is at the end of the residual limb.
- Pull up and invert the remainder of the sock over the residual limb (the sock will now be doubled over the residual limb).
- Ensure that there are no wrinkles in the fabric and that there is no “bunching up” of material at the distal end.



## APPLICATION AND MANAGEMENT OF BRACES – LEG

### POLICY:

1. The Licensed Nurse, in collaboration with Rehabilitation Services, is responsible for monitoring the correct application of leg-braces by Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) and resident, ~~if able~~.
2. ~~Leg b~~Braces require a physician order.
3. Obtain Physical Therapy or Occupational Therapy consultation for residents who used a brace prior to admission.

### PURPOSE:

To support ~~weakened muscles and to prevent further contractures of resident's leg through the~~ proper application and management of leg-braces.

### PROCEDURE:

#### A. EQUIPMENT

Brace with label for resident's name

~~Supportive shoes~~

~~Shoehorn~~

~~Lotion for skin care~~

Other devices as necessary (i.e. ~~S~~ocks or stockings ~~free of holes or mends~~, shoehorn, etc.)

#### B. CARE OF RESIDENT WITH LEG-BRACE

1. Review leg-brace application with Rehabilitation if unfamiliar with device.
2. ~~CNA or PCA~~Nursing staff will checks leg-braces for any missing or loose screws or loose or worn-out straps or buckles prior to putting leg brace to resident.
3. CNA or PCA will check skin at least every shift, and before and after applying brace, for any redness, irritation, or breakdown ~~before and after applying leg brace.~~
4. Refer to Physical Therapist if leg-brace is worn-out or ill-fitting. Have the brace checked periodically by the orthotist in conjunction with the Physical Therapist.
5. Consult with Wound Care Specialist for complex skin conditions.
6. Consult with Rehabilitation Services, ZSFG or LH Clinic to obtain a replacement brace if necessary.

#### D. REPORTING /DOCUMENTATION

1. ~~4.~~Treatment Administration Record:
  - a. Document brace application and removal.
  - b. Document skin checks every shift

~~4.~~Resident Care Plan:

Application and Management of Braces—Leg

- 2. a. Obtain and initiate a Resident Care Plan  
~~a-b.~~ Document use of the Brace.
- 2. Interdisciplinary Progress Notes:
  - a. Record resident level of skill and progress toward self-care and use of brace.
  - b. Record teaching in care of appliance and safety of use.
- 3. DNCR:
  - ~~a. Initial brace application on Rehabilitation Sheet~~
  - ~~b-a.~~ Monitor and document any redness, irritation, or breakdown and R report skin changes to Licensed Nurse.

**REFERENCES:**

Nettina, S., *The Lippincott Manual of Nursing Practice*, 9<sup>th</sup> edition, 2010  
Sorrentino, *Mosby's Textbook for Nursing Assistants*, 6<sup>th</sup> Edition, 2004

Revised: 8/2000, 2/2010, 4/2016

Reviewed: \_\_\_\_\_

~~Reviewed by \_\_\_\_\_ and no revision recommended at this time.~~

Approved: \_\_\_\_\_

<p>For Ghe use only:  Date sent to Policy Reviewer _____  Date received from Policy Reviewer _____  Date reviewed by NEC _____  Date approved by NEC _____  Date routed to MEC _____  Date emailed to Karina _____</p>
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## ENTERAL TUBE FEEDING MANAGEMENT

### POLICY:

1. Enteral nutrition is utilized as a last resort when the resident is unable to consume sufficient oral nutrition and according to the resident's goals of care.
- ~~4.2. Simple balloon gastrostomy tubes will be changed at least every 3 months, and as needed, unless physician order's otherwise.~~
- ~~2.3.~~ For acute management of nutritional support, enteral nutrition may be a short-term intervention.
- ~~3. All enteral tubes (Nasogastric, Gastrostomy, & Jejunostomy) will be managed in a standardized manner by physicians and nurses to promote patient safety and to reduce the risk of adverse events.~~
4. The Licensed Nurse/Team Leader checks the feeding pump at the beginning of the shift to verify that the pump program is correct per physician's order.
- ~~5. A Registered Nurse (RN), who has demonstrated knowledge and skill, may replace a simple dislodged or clogged G-tube, (not PEG) with an insertion tract  $\geq$  6 weeks old, may be replaced with a facility-approved balloon type G-tube by a LHH Registered Nurse (RN), who has demonstrated knowledge and skill, unless the physician orders otherwise.~~
- ~~6. If an insertion tract is less than 6 weeks old, a dislodged G-tube cannot be reinserted by a LHH RN.~~
- ~~7.5.~~ No attempts should be made to replace ~~these~~ newly placed tubes (Refer to LHHPP File # 26-03).
- ~~8.6.~~ Any tube replacement should have position confirmed by gastrografin prior to use.

### PURPOSE:

All enteral tubes (Nasogastric, Gastrostomy, & Jejunostomy) will be managed in a standardized manner by physicians and nurses to promote patient safety and to reduce the risk of adverse events.  
~~To provide guidance for safe administration of enteral feeding and to prevent complications associated with enteral nutrition.~~

### DEFINITIONS:

1. **Nasogastric Tube (NGT)** refers to a tube that provides access to the stomach through the nose. **Nasointestinal tubes (weighted tubes) are not inserted by LHH nurses.**
2. **Gastrostomy Tube (G-tube)** refers to a tube that is initially placed by surgeons or interventional radiologists (IR), or gastroenterologists through the skin of the abdomen and secured in the stomach and includes balloon-type G tubes, pigtails, mushroom tubes, and MIC tubes.
3. **Jejunostomy Tube (J-tube)** is a specialized feeding tube inserted into the jejunum by surgeons or interventional radiologists (IR), or gastroenterologists. **A J-tube is not to be replaced at Laguna Honda although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR.**

**PROCEDURES:**

**A. Equipment**

Gather all equipment needed from the neighborhood supply room.

**1. NGT Insertion**

Appropriate sized NGT depending on indication (i.e., feeding vs decompression)  
Catheter plug  
Clean gloves  
Towel and mouth wipes  
Emesis basin  
Water-soluble lubricant  
Tongue depressor  
Micropore tape 1/2" width; about 3" or 4" length

**2. G-tube Replacement**

Appropriate Gastrostomy tube size  
Clean gloves  
15 – 20 ml syringe(s) for balloon inflation and deflation, if needed  
Sterile water  
4 x 4 gauze (2 packages)  
Normal saline  
Water-based Lubricant  
4 x 4 drainage sponge for dressing G-tube site  
Thin hydrocolloid (e.g., Duoderm) if skin is excoriated  
Small waste disposable bag

**3. For administration of meds, flushing tube, and checking residual**

60 ml feeding syringes  
Luke warm water

**B. Reinsertion of Dislodged or Replacement of Enteral Tubes**

**1. Insertion of NGT**

A dislodged NGT shall be replaced by the licensed nurse unless the physician orders otherwise. Radiologic verification of tube placement shall be obtained each time a NGT is placed or replaced.

**Procedure for Insertion of NGT:**

- a. Educate resident about the procedures (insertion or removal) in advance and ensure resident's privacy throughout procedures.
- b. Follow standard (infection control) precautions.
- c. Refer to EBSCO link for detailed information regarding insertion, including estimating tube length required to intubate stomach; lubricating tube; positioning resident during and after

- procedure; verifying placement; and securing tube:  
<http://web.a.ebscohost.com/nrc/pdf?sid=e0bc3f29-ee7c-4b41-aa19-040ae56deea0%40sessionmgr4005&vid=1&hid=4212>.
- d. Verify NGT placement before initiating feeding, connecting to suction, or administering medications by aspiration of gastric content **AND** length of the tube (See Procedures C-3 Positioning)
  - e. Obtain radiologic confirmation of placement after each NGT insertion.
  - f. For gastric suction, connect NG tube to intermittent gastric suction machine turned on low suction unless physician orders otherwise.
  - g. Provide regular oral care including inspection of the back of the mouth to check for coiling of tube.

#### Procedure for Removal of NGT:

Follow EBSCO link for detailed information regarding removal of NGT:

<http://web.a.ebscohost.com/nrc/pdf?sid=942df883-7bd3-4705-b094-bdfb1249c7c9%40sessionmgr4004&vid=1&hid=4212>.

## 2. Replacement of G-Tube

- a. All gastrostomy tubes reinserted at LHH will have placement confirmed by gastrografin prior to use either at LHH or San Francisco General Hospital (SFGH). If the gastrostomy tube is replaced at LHH but no radiology technician is available at LHH (holiday or uncovered weekend day), the patient may be transferred to SFGH Emergency Department (ED) for gastrografin study.
- b. The LHH physician will check the radiology reading prior to use of a reinserted tube. If there is a question about tube placement, the tube will be reinserted in the ED. There will be direct verbal communication from the radiologist at SFGH to the physician at LHH confirming placement prior to use of the tube and/or if any questions arise about tube placement.
- c. If the gastrostomy tube is unable to be reinserted at Laguna Honda:
  - i. During weekdays, call SFGH IR to arrange placement as soon as possible.
  - ii. On weekends/holidays, transfer the patient to the ED at SFGH for tube reinsertion. There will be direct communication between the radiologist at SFGH and the LHH physician confirming placement prior to use of the tube.
  - iii. If there is a physician order and the resident can tolerate NGT placement, an NGT can be placed temporarily until an IR appointment is available (See Procedure, section B - 1).
  - iv. When there is a delay in resuming enteral nutrition and medications and/or an NGT cannot be placed, intravenous fluids and medications may be required.
- d. Keep a replacement gastrostomy tube of the same size as resident's existing tube available in the neighborhood for emergency replacement. Gastrostomy tubes are available from Central Supply.
- e. Replacing a G-tube (insertion tract  $\geq$  six weeks old) due to accidental expulsion or clogging:
  - i. The nurse will **immediately** insert a balloon-type gastrostomy tube of the same size to prevent closure of the stoma and then inform the physician.

- ii. If the nurse or physician is not able to insert the gastrostomy tube, a Foley urinary catheter may be inserted to keep the stoma open, unless the physician decides to exercise other options.
  - iii. If a Foley was inserted, it is to be replaced by a regular gastrostomy tube by either Gastroenterology Clinic, or a general surgical clinic, or another staff physician at the earliest opportunity.
- f. A dislodged gastrostomy or jejunostomy tube that is less than 6 weeks old shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.
- a.—

### Preparation and Procedure for Replacement of the Gastrostomy Tube

- a. Refer to EBSCO link: <http://web.a.ebscohost.com/nrc/pdf?sid=1585ab2e-76a6-4364-b50a-a09b9f91eca5%40sessionmgr4004&vid=2&hid=4207>
- b. If an existing tube has an internal bumper, do not remove the existing tube, inform the physician to request for removal alternative (e.g., removal at Gastroenterology Clinic).
- c. The tube should rotate freely once the balloon has entered the stomach). **Never force tube against resistance. If resistance is met, discontinue insertion and notify physician immediately.**
- d. Never use air or other fluids to fill the balloon. Never overfill or underfill balloon. If the physician immediately.
- e. Allow for slight in-and-out play of tube by sliding the external bumper back approximately 0.5 - 1 cm from the stoma. **If the gastrostomy does not have an external bumper, tape tubing securely** so that the balloon is against the internal abdominal wall.
- f. Measure the tube length from insertion site at the stoma to the distal end of tube port(s) and record in the care plan and interdisciplinary progress notes.
- g. Apply and tape a 4x4 drainage sponge over the external bumper as needed (e.g., drainage present).
- h. If skin is irritated, a hydrocolloid dressing may be applied directly to the skin, underneath the external bumper to protect the skin.
- i. Notify physician of replacement and request verification with radiography and gastrografin prior to using the tube for nutrition and/or medication administration.
- j. Complete an Unusual Occurrence (UO) report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

## C. Administration of Formula Feeding (1-6), Maintaining Tube Patency (7), Intermittent Gastric Suction (8)

### 1. Types of Enteral Nutritional Support

**Closed System** is used for enteral nutritional support when products are available in pre-filled closed containers. Closed systems are preferred whenever possible to reduce opportunity for contamination. Closed enteral containers must be labeled with the resident initials, bed number, rate, date and time container is hung. The labeled date and time on the container also applies to the tubing since both are one closed system. Closed enteral containers will be spiked only once with a new tubing set. Tubing sets are never to be re-used and will be discarded along with the

used container. Closed enteral containers and attached tubing are discarded when the container is empty, OR within 48 hours after closed enteral container is hung.

**Open System** is used for enteral nutritional support when products are not available in pre-filled closed containers. Open systems require nutritional products to be transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing. Open enteral bags must be labeled with the resident's name, bed number, formula, rate, date and time the bag is hung. The date and time on the bag also applies to the tubing as both are one system. Open enteral bags used for formula must be discarded after each use. Open enteral bags used solely for water must be discarded within 48 hours after they are initially hung.

Refer to Appendix 1 for Preparation for Enteral Nutritional Support – Closed and Open System.

**2. All enteral tube feeding orders for NGT, G-Tube, and J-Tube will include:**

- a. Name of the formula; amount of formula to be given, duration, and frequency if intermittent via pump; rate and duration of feeding if continuous via pump; amount of formula to be given and frequency if bolus by gravity.
- b. Amount and frequency of free water administration through the enteral tube.
- c. Gastric residual parameters as ordered by MD.
- d. Type and size of enteral tube
- e. G-tube or J-tube site care, NGT care
- f. Request physician order all medications be in liquid form to be administered via enteral tube (MD may adjust this order as needed).

**3. Positioning**

Prior to starting formula feeding, elevate the resident's head of the bed to a minimum of 30 degrees during feeding and for 30-60 minutes after feeding unless otherwise ordered by MD. If necessary to lower the HOB for a procedure (such as linen changes or incontinence care), feedings should only be stopped for a short period of time and restarted with HOB re-elevated as soon as procedure is completed.

**4. Checking Enteral Tube for Correct Placement**

1. Check the length of tubing for inward or outward migration before each intermittent feeding, or daily for continuous feedings. Notify the physician if migration has occurred.
2. For all enteral tubes (aspiration): With a 60 ml catheter tip feeding syringe, gently aspirate and visually inspect aspirations. Gastric secretions may appear clear and colorless or pale yellow or green, while small bowel secretions are often brown colored. Measure and return all gastric contents to prevent fluid and electrolyte imbalance. Then flush tube with 30 ml of water (20 ml if fluids are restricted) to keep tube patent. Notify the physician if unable to aspirate gastric secretions or color is concerning.
3. If there is a question about the enteral tube placement do not proceed with administration of medication or feeding until correct placement has been verified. If NGT is in place, examine oropharynx. If there is coiled tubing, gently remove the tubing immediately to prevent airway obstruction. Inform the physician immediately if there are questions about placement.

**5. Measuring Gastric Residual**

## **Enteral Tube Feeding Management**

- a. Stop continuous feedings for several minutes before aspirating, measuring, and returning gastric residuals every 6 to 8 hours. Aspirate, measure, and return gastric residual before each intermittent feeding.
- b. If the gastric residual volume is > 150 ml, notify physician, and aspirate, measure, and return gastric residual every 2-4 hrs until resident has exhibited the ability to empty his/her stomach, at which time tube feeding may be continued or re-started.

Monitor for abdominal distention and/or pain, nausea, vomiting, or complaints of fullness, and or persistent residual volume > 150 ml occur, notify physician for evaluation.

- c. Jejunostomies require continuous infusion of nutritional supplements or water rather than bolus feedings.

### **6. Maintaining Patency of Enteral Tube**

To keep the GT / JT patent, flush tube with 30 ml of water (20 ml if fluids are restricted) with a 60 ml syringe:

- a. Before and after each intermittent feeding.
- b. Every 4 to 6 hours during continuous feeding.
- c. Before and after administering medication.
- d. After withdrawing and returning gastric aspirate when checking tube placement and residual volume.
- e. As needed to keep tube patent (e.g., small French tubes or higher fiber formulas).
- f. If the gastrostomy tube becomes clogged, draw up 10 ml of warm water or saline using a 10 ml syringe and use gentle pressure to instill the fluids into the tube to clear the obstruction.

### **7. NGT use as Gomco Intermittent Gastric Suction**

- a. Place curved basin beneath connection of nasogastric tube and suction machine, and disconnect.
- b. Hook suction tube to the suction machine.
- c. After instilling medication and/or formula and flushing with 30 ml of water, plug the NG tube for 1-1/2 hours or as ordered by the physician, before reattaching to the suction machine.
- d. Rinse syringe and curved basin and leave at bedside.

## **D. Administration of Medication (s) Through Enteral Tube**

1. Request medications be in liquid form whenever possible. If liquid form is not available from Pharmacy and tablet form must be used, crush tablets (except for enteric coated or sustained release medications). Dissolve tablets or dilute medication sufficiently for medication to pass through the tube. Refer to Medication Administration (NPP J 1.0).
2. Preferred administration of medications or fluids through enteral tubes is by gravity with 30 ml of water given before and after medications. Gentle pressure using a 60 ml catheter-tip syringe may be used as needed.
3. Give medication at the appropriate time in relation to feeding. Some medications should be given with food, while some should be given on an empty stomach with tube feeding withheld for a prescribed interval before and after medication is given (e.g., Dilantin suspension). For proper action, some medications must be delivered into the stomach rather than into the duodenum or



**Enteral Tube Feeding Management**

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jejunum. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility. Refer to Medication Administration (NPP J 1.0 Appendix 1).

4. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.
5. Confirm correct placement of enteral tube (refer to Procedure C-4: "Checking Enteral Tube for Correct Placement" as outlined above).
6. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 30 ml (20 ml if fluids are restricted) of water using gravity or gentle pressure with the syringe.
7. Make sure medicine is sufficiently dissolved. Draw up medicine into 60 ml syringe or instill tip of syringe into the end of the enteral tube and pour medication into the syringe. Allow medication to drain into the tube by gravity (gentle pressure on syringe plunger may be used as needed).
8. After all medication is administered, instill approximately 30 ml of water to flush medication.
9. If medications are given separately, rinse the tube with 5 ml of water between medications.

**E. Reassessment of Enteral Feeding**

1. Enteral Feeding is to be held for possible indications of:
  - a. Aspiration, such as vomiting, choking, coughing, frothy sputum, tachycardia, respiratory distress, or fever
  - b. Diarrhea
  - c. Fluid and Electrolyte Imbalance
  - d. Slow gastric emptying, such as high residual volume or feelings of fullness
  - e. Peritonitis, such as abdominal pain and/or bloating, constipation, fever, nausea, vomiting, diarrhea, weakness, dizziness, dyspnea, tachycardia, tachypnea, and inability to pass gas or feces, and dehydration.
2. Notify Physician to reassess enteral feeding and/or complications if:
  - a. Tube feeding is held for possible aspiration, diarrhea, fluid and electrolyte imbalance, slow gastric emptying, or signs of peritonitis. Enteral feeds will be resumed by physician order, which may include radiologic evaluation or reassessment of the goals of enteral feeding.
  - b. Patient has unplanned weight gain or loss greater than 5% in a month, 7.5% in 3 months, or 10% in 6 months or if a reassessment of goals of nutritional support is indicated. Refer to NPP G 4.0 (Measuring the Resident's Height and Weight).

**F. Care of Enteral Tube**

**1. NGT**

- a. Nasogastric tube is to be changed every 4 weeks or as indicated, alternating nostrils if possible. Licensed Nurse will schedule on TAR when the NGT needs to be changed.

- b. Change tape over the nose bridge as needed.

## 2. G-Tube and J-Tube

- a. Inspect skin daily for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage.
- b. New tube (insertion tract less than 6 weeks old):
  - i. Explain procedure to resident.
  - ii. Wash hands and wear gloves prior to providing site care.
  - iii. For the first 7 to 10 days after initial insertion, stabilize tube with one hand while cleaning skin to remove crusts.
  - iv. Clean the site with clean swabs moistened with normal saline.
  - v. Dry skin thoroughly.
  - vi. A waterproof ointment may be used to protect skin from drainage. If a dressing is needed, choose one that absorbs drainage and protects the skin, such as a polyurethane foam dressing.
  - vii. If a dry 4 x 4 drainage sponge dressing is applied over the external bumper, change it as soon as the dressing becomes wet.
- c. Established tube (insertion tract at 6 weeks or older). Daily stoma site care for a healed site.
  - i. Explain procedure to resident.
  - ii. Wash hands and wear gloves prior to providing site care.
  - iii. Remove old dressing if there is one and inspect skin around the stoma for signs of irritation, drainage, or leakage. Report abnormal findings to physician as needed.
  - iv. Clean the skin gently. Start at the site and move outward, using moistened cloth or gauze. Clean under external bumper with cotton tipped applicator. Rinse and dry skin thoroughly.
  - v. Avoid using a dressing if possible, but if needed, apply and tape a 4x4 drainage sponge over the external bumper which must be kept close to the skin.
  - vi. If skin is irritated, hydrocolloid dressing may be applied directly to the skin, underneath the bumper to protect the skin.
    - 1. Edges may be taped with 1" hypoallergenic tape to reduce peeling during bathing.
    - 2. Stabilize the tube with tape if needed to prevent movement.
    - 3. Hydrocolloid dressing may be left undisturbed for up to three days, as long as there is no visible accumulation of fluid underneath the dressing.
    - 4. If using hydrocolloid dressing, staff must check skin daily for any redness or skin breakdown.

## G. Documentation

### 1. Goals of Medical Enteral Feeding

- a. Nutritional and Quality of Life goals are documented on the Resident Care Plan (RCP) and quarterly Resident Care Conference (RCC) note.
- b. Goals of enteral feeding may be documented in the Advanced Directives by the physician.

**2. Integrated Progress Note documentation, including weekly and monthly summaries, and as needed**

- a. Replacement of tubes including reason, resident's tolerance, and any difficulty or complications encountered.
- b. Any other problems with enteral tube management (e.g., frequent obstruction, etc.)
- c. Condition of NGT, gastrostomy, or jejunostomy site.
- d. Resident's tolerance of the feeding.
- e. Any resident or family teaching done and evaluation of learning.
- f. Permanent removal of enteral tube and resident's tolerance of procedure.

**3. Treatment Administration Record (TAR)**

- a. License Nurse records and initials the following:
  - i. Name of the formula; amount of formula to be given, duration, and frequency if intermittent via pump; rate and duration of feeding if continuous via pump; amount of formula to be given and frequency if bolus by gravity.
  - ii. Amount and frequency of free water administration.
  - iii. Gastric residual parameters. Record any gastric residual seen when checking tube placement.
  - iv. Enteral tube site care.
  - v. Document daily enteral feeding supplies used on the Enteral Nutrition Charge Form. Refer to LHHPP 50-04 (Enteral Charge Form Procedure).
- b. Continuous and Intermittent Enteral Nutrition:
  - i. Prior to the end of EACH shift, the Licensed Nurse/Team Leader:
    - 1. Checks the feeding pump and note the volume "FED" and the volume "FLUSH".
    - 2. Documents the volume "FED" and the volume "FLUSH" at the end of the shift in the TAR.
    - 3. Clears the pump of the volume "FED" and the volume "FLUSH".
  - ii. Prior to the end of P.M. Shift, the Licensed Nurse/Team Leader:
    - 1. Adds the volume "FED" for each shift to get the 24-hour enteral formula intake and document in the TAR.
    - 2. Add the volume "FLUSH" for each shift to get the 24-hour enteral water flush intake and document in the TAR.

**4. Resident Care Plan**

- a. On enteral tube / feeding care plan, identify the clinical indication, as noted by the MD, which necessitates enteral tube placement and enteral feeds.
- b. Include any related problems or resident needs that are not otherwise addressed in treatment record or care plan front card.
- c. The Registered Nurse assesses and records the type, size and length of the tube in the Front Card of the RCP.

**APPENDICES:**

Appendix 1: Preparation for Enteral Nutritional Support – Closed and Open System

Appendix 2: Enteral Pump Hang Tag provided by the manufacturer

**REFERENCES:**

Robin Bankhead, Joseph Boullata, Susan Brantley, Mark Corkins, Peggi Guenter, Joseph Krenitsky, Beth Lyman, Norma A. Metheny, Charles Mueller, Sandra Robbins, Jacqueline Wessel and the A.S.P.E.N. Board of Directors, **A.S.P.E.N. Enteral Nutrition Practice Recommendations**; *JPEN J Parenter Enteral Nutr* 2009; 33; 122 originally published online Jan 26, 2009  
<http://web.ebscohost.com/nrc/search?sid=f66bbea8-b499-4b6c-8b69-eaf6d9306e53%40sessionmgr115&vid=2&hid=117>

**CROSS REFERENCES:**

LHHPP File: 26-03 Enteral Tube Nutrition  
LHHPP File: 50-04 Enteral Feeding Charges

NPP G 3.0 Intake and Output  
NPP G 4.0 Measuring the Resident's Height and Weight  
NPP J 1.0 Medication Administration and Appendices

Adopted: 8/2002, 8/2005, 8/2009; 03/10/2011, 07/12/11; 01/13/2015

NEW: 05/28/13

Reviewed: 01/13/2015

Approved: 01/13/2015

## GASTRIC SPECIMENS

### POLICY:

1. ~~A. Obtain a physician's written order is required for sending a gastric specimen to the laboratory~~desired test.
2. Licensed nurses collect gastric specimens.

### PURPOSE:

To collect gastric contents for diagnostics.

### PROCEDURE:

~~a.~~

#### A. Equipment:

- a. Basin for emesis (for gastric samples via emesis)
- b. 35-60 ml syringe
- c. Completed lab request
- d. Sterile container with screw-top cover
- e. Label for container
- f. Clear plastic bag

#### A.B. Laboratory requisitions

1. Completed ~~self-stick~~self-stick specimen identification label (date and time collected, stamped ~~laboratory~~ addressograph containing resident name, ~~laboratory ID number, and~~ neighborhood, ~~and bed number~~) and affix to the specimen container.
2. Completed requisition must be stamped with the ~~laboratory~~ addressograph and completed accurately, including the physician's ID number and ICD ~~-910~~ codes.

#### B.C. Obtaining a gastric sample if resident has had emesis:

##### ~~1. Equipment~~

- ~~a. Emesis basin (new)~~
- ~~b. Completed lab request~~
- ~~c. Sterile container with screw-top cover~~
- ~~d. Label for container~~
- ~~e. Clear plastic bag~~

~~2.1.~~ Provide resident with privacy.

~~3.2.~~ Collect approximately 50ml, transfer to a sterile container with a screw top, and tightly close the container.

## Gastric Specimens

4.3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clipped or placed the laboratory requisitions in the outside pocket specimen plastic bag.

5.4. Assist resident to rinse his/her mouth.

### C.D. Obtaining a gastric sample directly from the stomach:

~~1.~~ 1. Obtain and follow the specific instructions provided by the physician or clinical lab for the clinical test

~~2.1.~~ ~~test~~ to be performed.

#### 2. Equipment

~~a. completed lab request~~

~~\_\_\_\_\_ b. sterile container with screw top~~

~~\_\_\_\_\_ c. label for container~~

~~\_\_\_\_\_ d. specimen plastic bag~~

~~\_\_\_\_\_ e. 50 ml syringe to withdraw contents~~

3.2. Position resident in High Fowlers position. Using a ~~35-560~~ ml syringe to withdraw 5-10 ml of gastric contents.

~~3.~~ If multiple specimens are required, be certain that N/G tube is taped in place, if it is new.

4.3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clipped or placed the laboratory requisitions in the outside pocket specimen plastic bag.

### D.E. Disposition of Specimen

1. Place the label on the container, place specimen(s) container in a clear plastic bag(s), and attach requisition(s).

2. Store gastric specimen in laboratory refrigerator until pick-up.

3. Laboratory Operation Hours and Regular Courier Pickup Hours (Refer to Clinical Laboratory P&P A1)

4. For STAT-order, inform Lab Technician to include gastric specimen in the earliest lab courier pick-up time.

~~1. Laboratory Operation Hours and Regular Courier Pickup Hours~~

#### ~~a. Monday to Friday~~

~~i. Lab Hours: 6:00 A.M. to 4:40 P.M.~~

~~ii. Courier Pickup Hours:~~

~~\_\_\_\_\_ 1<sup>st</sup> pick-up: \_\_\_\_\_ 8:30 A.M.~~

~~\_\_\_\_\_ 2<sup>nd</sup> pick-up: \_\_\_\_\_ 11:00 A.M.~~

~~\_\_\_\_\_ 3<sup>rd</sup> pick-up: \_\_\_\_\_ 2:30 P.M.~~

~~\_\_\_\_\_ Final pick-up: \_\_\_\_\_ 6:00 P.M. \_\_\_\_\_ specimen dropped off at Pavilion Mezzanine Rehab.~~

#### ~~b. Weekends and Holidays~~

~~i. Lab Hours: 10:00 A.M. to 2:00 P.M.~~

~~ii. Courier Pickup Hours:~~

## Gastric Specimens

- ~~— 1<sup>st</sup> pick-up: — 11:30 A.M.~~
- ~~— Final pick-up: — 2:00 P.M.~~

- ~~2. For regular working hours, send urine specimens directly to the Clinical Laboratory by any nursing staff for regular lab courier pick-up. All specimens that will be going out for 6:00 P.M. for final courier pick-up should be dropped off at the Pavilion Mezzanine Rehab. For STAT order, inform Lab Technician to include gastric specimen in the earliest lab courier pick-up time.~~
- ~~3. For non-STAT order, on weekends, holidays, or after hours, urine specimens are stored in the laboratory refrigerator located in the North 1 and South 2 Residence Buildings. A designated A.M. shift nursing staff will bring all the urine specimens with requisitions to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.~~
- ~~4. For all other STAT order collected on weekends, holidays, or after hours, Licensed Nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier to pick-up specimen.~~

### E.F. Documentation

1. Licensed Nurse or Unit Clerk will transcribe physician's laboratory ordered test.

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

### ATTACHMENTS:

None

### REFERENCES:

Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 5<sup>th</sup> edition, Elsevier Inc., 2012.  
~~Elkins, Perry & Potter, Nursing interventions & Clinical Skills, Mosby Inc., 4<sup>th</sup> edition, 2007.~~

~~Lippincott, Williams, and Wilkins. Best Practices: Evidenced-Based Nursing Procedures, 2<sup>nd</sup> Edition, Springhouse Corporation, 2007~~

### CROSS REFERENCES:

Clinical Laboratory Policies and Procedures  
A1 Clinical Laboratory

Nursing Policies and Procedures:

~~E 35.0 Nasogastric Tube Insertion and Removal~~Enteral Tube Feeding Management

~~Nursing policies and Procedures: H 6.0 STAT or Routine Clinical Laboratory Protocol~~After Hours  
STAT Blood Draw

~~Departmental LH: Clinical Laboratory Policies and Procedures~~

Revised: 11/2000, 11/2008, 10/2010, 12/2010, 04/2016

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**Gastric Specimens**

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File: H 4.0 ~~October~~April, 2019~~6~~, Revised  
*LHH Nursing Policies and Procedures*

Reviewed: 12/27/10



Oxygen Administration

## OXYGEN ADMINISTRATION

### POLICY:

- ~~1. 4. —~~ A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.
2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.
- ~~1. —~~
- ~~—~~
3. Residents requiring continuous oxygen ~~at greater than 2 lpm~~ shall be placed in a room that has wall oxygen.
4. Oxygen tank shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.
- ~~2. —~~
- ~~3. 2. — Oxygen is not to be given without physician approval for residents with COPD, or isolated blue limbs, or for residents where orders have been written specifically for "No Oxygen".~~
- ~~3. A licensed nurse may administer oxygen (with mask or bag ventilator) pending the physician's arrival in emergencies of cardiac arrest, diffuse cyanosis, seizures, witnessed or suspected aspiration, choking (after attempts to clear airway), chest pain, angina, suspicion of angina in residents with known coronary artery disease, acute respiratory distress, or massive acute bleeding.~~
- ~~4. The physician is to be contacted as soon as possible when oxygen is given to residents who do not have specific orders for oxygen.~~

### PURPOSE:

To safely ~~give~~ administer oxygen therapy ~~to the hypoxic resident to increase the level of oxygen concentration in the tissues.~~

### PROCEDURE:

#### A. Equipment:

1. Obtain ~~from Unit Supply, as needed:~~
  - ~~—~~ Water-soluble lubricant and 4 x 4 gauze sponges
  - ~~—~~ Nasal cannula, nasal catheter, mask, connecting tubing
  - ~~—~~ Tracheostomy adaptors - mask or collar
  - ~~—~~ Humidifier if needed. oxygen delivery system supplies from neighborhood storage room or central supply. (The day shift is to order humidifiers from Central Supply to have available on the unit for the A.M. shift.)
2. Obtain from Central Supply, as needed:
  - "NO SMOKING" sign(s)

## Oxygen Administration

Small "E" tank oxygen cylinder with valve protection device attached ~~and gauge wrench.~~ (Each ~~Unit Neighborhood~~ will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)

~~Large "H" tank with valve protection device as needed for resident use.~~

Appropriate regulator

~~"Christmas tree"~~ Compressed Air Connector ~~adapter~~ if no humidification required

Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.~~oxygen.~~

- ~~3. The licensed nurse is to verify the availability of emergency oxygen and supplies in the treatment room every morning, and record on the Emergency Equipment Checklist.~~

### B. Safety measures for oxygen are to be followed.

1. There is to be "NO SMOKING OXYGEN IN USE" in the area of oxygen use or storage.
2. Residents and visitors are to be informed of the risks of smoking when oxygen in use. ~~"No Smoking" policy as needed.~~
3. "OXYGEN IN USE" ~~"NO SMOKING"~~ ~~s~~ Signs are to be clearly visible:
  - a. on neck of oxygen or compressed air tanks in use or stored
  - b. outside resident's room
  - ~~c. at the doorway to the unit when oxygen or compressed air is used~~
  - ~~d. on the treatment room door for emergency oxygen in storage~~
4. **No alcohol or tincture, oil, glycerin, Vaseline or petroleum** product is to be used on or near residents receiving oxygen.
5. ~~5.~~ When oxygen tubing is not in use, make sure it is turned off and stored in bags.
- ~~4.6.~~ Do not connect or disconnect electrical devices such as suction machines, electric razors and radios cell phones or any heat producing device during oxygen treatment.
6. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.
7. If fire breaks out on the ~~unit neighborhood~~, turn off all oxygen sources~~oxygen~~. If a resident cannot survive without oxygen therapy, move resident, bed to a safe area before resuming oxygen.
8. If oxygen cylinders are required:
  - a. ~~a.~~ Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
  - b. ~~b.~~ Always look at the cylinder label gauge to determine contents before administering any.
  - ~~c. When an oxygen tank is put into use, tear off the bottom one-third of the tag on the neck of the tank which reads "full." The lower portion of the tag will then read "in use." When the tank has 200 pounds pressure left in the tank, tear off the "in use" portion of the tag, which will now identify the tank as "empty." Get a full tank from Central Supply if resident is to continue receiving oxygen. Oxygen concentrators are also an option for oxygen flow rates up to 5 lpm.~~
  - c. ~~d.~~ Oxygen cylinders in storage shall be equipped with valve protection devices, and stored in oxygen cabinet.
  - e. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.

## Oxygen Administration

- d. ~~f.~~—Cylinders valves shall be closed before moving cylinder on all tanks including empty cylinders.

### C. Setting up and monitoring oxygen cylinders:

1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and tighten using wrench position so that regulator is perpendicular to tank for easy reading.
4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be pasted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and ~~Christmas-compressed air connector~~ will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder.
9. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

### D. Breaking down oxygen cylinders.

1. Remove regulators from cylinders.
2. Place valve covers on cylinders.
3. Return empty cylinders to Central Supply.

### E. Preparation of the Resident and Visitors:

1. Explain the procedure and reasons for it to the resident.
  - a. ~~a.~~—Show resident the catheter or mask to be used.
  - b. ~~b.~~—~~R~~Reassure resident that you will be checking him/her.
  - c. ~~c.~~—Elevate the head of the bed.
  - d. ~~d.~~—Check that the call light is accessible. Give instruction on how to operate the call light, if needed. Reassure the resident that you want him/her to turn on the call light to inform you of any difficulties.
  - e. ~~e.~~—If the resident is apprehensive, and if staffing permits, assign someone to stay with him/her until he adjusts.
2. Explain the "NO SMOKING" policy to the resident and visitors. ~~Residents are to smoke only in designated areas. Remove matches and cigarettes from unsafe smokers.~~

### F. Preparation of Equipment:

1. Place "NO SMOKING" signs according to policy.
2. Wash hands.
3. Connect tubing to the flowmeter or humidifier and the administering device.

## Oxygen Administration

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4. Assess equipment for proper functioning. Open oxygen flowmeter. There should be bubbles visible in the water of the humidifier, if used.

### G. Administration:

1. Apply and adjust nasal cannula, mask or catheter to resident. Check placement frequently. If needed, use 4 x 4 gauze to cushion tubing that presses against the face or ears. Keep skin clean and dry. Observe these skin areas for skin breaks when oxygen is prolonged.
2. Turn on the oxygen and adjust flow rates as prescribed.
3. Increase frequency of oral hygiene as needed by resident's condition.
4. Nasal oxygen administered at 4 liters or less/minute does not need to be routinely humidified.
5. When humidifiers are used with oxygen, use pre-filled humidifier.
6. ~~6.~~ All disposable oxygen administration devices shall be replaced every 24 hours. Daily, the AM shift licensed nurse will change all disposable oxygen devices, including but not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula or catheter, mask or tracheostomy mask, and replace with new devices. Documentation of the replacement shall be noted in the resident's treatment sheet.
7. Check oxygen flow rate at frequent intervals.
8. Observe the resident frequently for signs of insufficient oxygen which may include:
  - a. ~~a.~~ BP - increase above baseline or narrowed pulse pressure,
  - b. ~~b.~~ Pulse - tachycardia,
  - c. ~~c.~~ Respiration changes in rate, rhythm, depth, absence or presence of dyspnea,
  - d. Decreased mental alertness - confusion, restlessness,
  - e. Changes in skin and fingernail color, perspiration.
9. For Infection Control purposes, the opened nasal cannula, when not in use, will be stored in a clean bag.

### H. Methods of Administration

Refer to Respiratory Services Departmental Policies and Procedures in the Cross Reference Section or The Lippincott Manual of Nursing Practice listed in the Reference Section of this NPP for Administering Oxygen by Nasal Cannula, Simple Face Mask With/Without Aerosol, Venturi Mask (High air flow oxygen entrapment [HAFOE] system, Partial Rebreathing or Nonrebreathing Mask, Continuous Positive Airway Pressure Mask, or by Manual Resuscitation Bag.

### I. Documentation for Oxygen:

1. Order Sheet:  
When noting oxygen orders on the physician's order sheet, code with the letter "T" in the Code column and transcribe to treatment sheet.
2. Treatment Sheet
  - a. Front side of treatment sheet

## Oxygen Administration

- i. For continuous use of oxygen each shift, the licensed nurse signs her initials for the time and date opposite the order, then writes initials, signature and title in the signature section.
    - ii. For PRN use of oxygen, sign initials each time the oxygen is given.
    - iii. When treatment is given by the respiratory therapist, the licensed nurse circles the correct time box and writes "RT" and her initials. Respiratory therapist does his own documentation.
    - iv. The AM shift licensed nurse will replace all disposable oxygen administration devices every 24 hours. The replacement shall be noted in the front side of the resident treatment sheet.
  - b. Reverse side of treatment sheet – Progress Notes  
For PRN use of oxygen, each time oxygen is given, include a comment about how the oxygen was tolerated.
3. ~~Graphic Sheet~~ Electronic Charting Health Record  
  
Vital signs are recorded in the Electronic Health Record (LCR) ~~respiration and pulse PRN, based on the judgment of the nurse.~~
4. Integrated Progress Notes – Monthly/weekly summary or more frequent PRN charting based upon the resident's condition and the judgment of the nurse.
  - a. Resident's response to treatment including adverse reactions and tolerance to the procedure, which may include the following items, as applicable.
    - i. Date, time and person performing the procedure
    - ii. Oxygen liter flow rate.
    - iii. Method, frequency and duration of administration
    - iv. Specific assessments which may include vital signs, skin color, and level of consciousness.
  - b. Resident teaching done and the resident's level of understanding and compliance.
5. Include oxygen administration and respiratory status on the Resident Care Plan.

### REFERENCES:

Elkin, Perry and Potter; Nursing Interventions and Clinical Skills, 4<sup>th</sup> edition, 2007  
Lippincott, Williams, and Wilkins; Best Practices: Evidence-Based Nursing Procedures; 2<sup>nd</sup> edition, 2007  
Lippincott, Williams, and Wilkins; The Lippincott Manual of Nursing Practice; 9<sup>th</sup> edition; 2010

### CROSS REFERENCES:

Respiratory Services Policies & Procedures:

- A 2. Safety Regulations for Oxygen Therapy
- A 6. Oxygen Administration: Nasal Cannula
- A 7. Oxygen Administration: Simple- Oxygen Mask
- A 8. Oxygen Administration: Non-Rebreather Mask

**Oxygen Administration**

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A 9. Oxygen Administration: Venturi Mask

Revised: March/2006, April/2006, August/2009

Reviewed: \_\_\_\_\_

Reviewed by \_\_\_\_\_ and no revision recommended at this time.

Approved: \_\_\_\_\_

For Ghe use only: Date sent to Policy Reviewer <b>03/14/14</b> Date received from Policy Reviewer _____ Date reviewed by NEC _____ Date approved by NEC _____ Date routed to MEC _____ Date emailed to Karina _____
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Oxygen Device	FiO2 Delivered (approx. values)	Comments
Nasal prongs / cannula	1 lpm=24%    4 lpm=33% 2 lpm=27%    5 lpm=35% 3 lpm=30%    6 lpm=38%	-O2 flow should be < 6 lpm -Humidity not required for flows < 4 lpm -O2 concentration will vary with patient breathing pattern
Nasal moustache / oxymizer	<u>Nasal Prongs</u> <u>Oxymizer</u> 3 lpm            1.5 lpm 4 lpm            2 lpm 6 lpm            3 lpm	-Never humidity -O2 conservation device, allows patient to cut O2 use in ½ -Not recommended for long term high flow use (>10 lpm)
Simple mask	Delivers 35-50% O2 @ flows of 6-10 lpm	-No humidity -Short term use only -Never use @ , 6 lpm
Non-rebreathing mask	Delivers 80-100% O2 @ flows of 12-15 lpm	-Never humidity -Never remove one-way valves -Reservoir bag must not collapse during inspiration, adjust flow accordingly
Aerosol mask	Delivers 28-100% O2 depending on dial setting	-Never use flows < 8 lpm -Use sterile water not normal saline in nebulization chamber -Double bottle or high flow set-up must be used with O2 concentration > 50%
Tracheostomy mask / hood	Delivers 28-100% O2 depending on dial setting	-Never use flows < 8 lpm -Use only sterile water -Double bottle for O2 >50% must always be on patient because normal anatomical humidification system is bypassed
Venturi mask	Delivers 24-50% O2 depending on which connector is used. Green: 24,26,28 & 30 % White: 35, 40 & 50%	-Never use bubbler humidifier -Never cover connectors -Most accurate way to deliver O2 -Ideal fro CO2 retainers or hypoxic drive patients

## **BLOOD ~~TRANSFUSION~~ PRODUCT ADMINISTRATION**

### **POLICY:**

- ~~1. There must be a written physicians order.~~
- ~~2.1. The transfusion of blood products ~~RBCs~~ is restricted to Pavilion Mezzanine Acute (PMA) ~~Unit M7A~~.~~
- ~~2. Only the skilled and knowledgeable Registered Nurse (RN) may administer blood products upon written physician order, utilizing the blood transfusion order set.~~
- ~~3. Packed Red blood cells (RBCs) are the only blood component transfused at Laguna Honda Hospital and Rehabilitation Center (LHH). registered nurses competent in blood component administration may perform this clinical procedure.~~
- ~~4.~~
- ~~5. Residents receiving transfusions are transported to M7A shortly before the procedure as "come & go residents".~~
- ~~6.~~
- ~~7. Typing and cross matching (T&C) of blood and dispensing of RBCs is done by the SFGH Blood Bank.~~
- ~~8.~~
- ~~9. A blood administration set with an in-line filter is used for all transfusions: New tubing will be used for each unit administered.~~
- ~~10.~~
- ~~11. Body substance precautions are used for all aspects of blood transfusion.~~
- ~~12.~~
- ~~13. Once the blood is issued, if the blood is not infused — it will be returned to the SFGH Blood Bank.~~
- ~~14.~~
- ~~15. Medications are NEVER added to blood or blood components.~~
- ~~16.~~
- ~~17. Red blood cells (RBCs) are the only blood component transfused at LHH.~~
- ~~18.~~
- ~~19. Residents are observed on M7A for up to one hour following transfusion.~~
- ~~20.~~
- ~~21. Any transfusion must be completed within 12 hours of blood issue from the SFGH Blood Bank in a quality controlled cooler and within 4 hours of removing the blood from the cooler for infusion to minimize the risk of bacterial contamination and growth.~~
- ~~22.3.~~

### **PURPOSE:**

- ~~1. To describe the procedure for ordering and receiving of blood products from the SFGH Blood Bank/Transfusion Service.~~
- ~~2. To describe the procedure for safe administration of blood products, products and initiating assessment, treatment and laboratory investigation in case of suspected transfusion reactions.~~

- ~~1. To safely restore blood volume.~~
- ~~2. To recognize symptoms of a transfusion reaction promptly and take appropriate action.~~



**Blood Product Administration** ~~Transfusion: Appendix A~~

*LHH Nursing Policies and Procedures*

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**PROCEDURE:**

**A. Equipment**

1. Blood Bank Requisition
2. IV pump and stand
3. Normal Saline (250 mL) bag
4. ~~Two~~ Y-blood administration sets with filters
5. I.V. tray/supplies (I.V. catheters, Alcohol wipes, etc.)
6. Blood transfusion documentation

**Obtain From**

LHH Laboratory/~~M7A~~ PM  
 CSR/~~PM~~ M7A  
~~PM~~ M7A  
~~CSR/PM~~ M7A  
~~PM~~ M7A  
~~PM~~ M7A

**B. Physician Orders/Consent**

1. Physician orders for blood transfusion must be written. The resident's SNF physician must write the following:
  - a. Type & cross match for PRBCs & number of units to be given
  - b. Date transfusion to be administered, given
  - c. Length of duration of transfusion for each blood product unit.
  - d. If indicated, p~~Pre-~~medications (such as acetaminophen or diphenhydramine to prevent or mitigate simple febrile or allergic reactions). Note: Caution should be utilized in those over age 65 years with the use of diphenhydramine (Beers Criteria). , respectively), may be included in the transfusion orders

**C. Request for Blood from SFGH Blood Bank**

1. The ~~RN- licensed nurse~~ or physician completes the blood bank requisition form with the following information:
  - a. Resident addressograph stamp (first/last name; medical record number, date of birth) ~~hospital #, DOB,~~
  - b. Physician identification: name, ID code # and beeper extension number.
  - ~~a-c.~~ LHH unit and phone number.
  - ~~b-d.~~ Transfusion request section must contain: Type & Cross (ABO, Rh, aAntibody sScreen); number of units of PRBCs; pre-transfusion lab results; reason for transfusion.
  - ~~e-e.~~ Signature of the person who collected the Blood Bank specimen from the resident with date and time of the blood collection.
2. The resident's blood specimen is obtained by the lab technician, RN, or ~~by~~ physician. If the resident has Central Venous Access Device -in the absence of the lab technician, OR by an RN if resident has a (CVAD), RN will draw the blood sample.
  - a. Specimen must be collected into a 10\_mL pink Blood Bank tube which must be filled completely.
  - b. The person collecting the blood must:
    - i. ~~D~~ date, time, and sign in the appropriate filed on the blood requisition form.
    - ii. Date, time and signature on the ID sticker on the blood tube are optional.
    - iii. Label the Blood Bank specimens in the presence of the resident.
  - ~~b. Note: Like all laboratory specimens, blood bank specimens must be labeled in the presence of the resident to safe-guard against specimen mix ups.~~

**Blood -Product Administration** ~~Transfusion: Appendix A~~

LHH Nursing Policies and Procedures

3. Blood specimens and requisition are delivered to SFGH Blood Bank by courier:
  - a. During the hours of 0600 – 1759, the lab tech will draw the Blood, take it to LHH lab, and contact a courier to deliver it.
  - b. Between the hours of 1800 – 0659, the unit nurse or physician will draw the blood specimen, appropriately label and sign, and notify the nursing supervisor to arrange for courier pick up.

**D. Blood Issue and Return**

1. Blood transfusion will be scheduled ~~for PM~~ M7A preferably between the hours of 0900 – 1800 on the day following completion of the type & cross ~~—match and when the blood is available.~~ The SNF neighborhood unit ~~L~~ licensed Nurse will notify ~~M7A~~ PMA RN when the type and cross ~~T&C~~ has been sent.
2. ~~PM~~ M7A personnel will contact the SFGH Blood Bank when the patient is ready for the transfusion.
3. Blood transfusion may be performed 7 days/week. ~~It is important that the resident be returned to his/her unit prior to 2300 on the day of the transfusion.~~
4. The PRBCs will be delivered by the cab driver directly to the Nursing Office ~~PMA. (NO). If N.O. is closed, the blood will be delivered to M5 and the staff nurse will contact the nursing supervisor to pick up the blood and take directly to M7A.~~
5. Units of PRBCs are sent to LHH with a computer label attached for checking resident and unit.
6. The RN staff person receiving the blood delivery verifies that the blood has not expired, checks the stamped date and time on the cooler label to ensure that no more than 4 hours has elapsed since the blood was placed in an insulated blood bank cooler (which keeps the temperature safe for administration within 12 hours of being placed into the cooler) and signs the delivery receipt.
7. Blood that is outdated or received past 4 hours from issue of the will not be accepted and is returned to SFGH Blood Bank ~~will not be accepted and is returned to the SFGH Blood Bank.~~
8. ~~PM~~ M7A RN nurse attaches the delivery receipt onto the yellow laboratory report page in the resident's medical record.
9. If the blood is not to be transfused within the time frame, or for some other reason is not transfused, return the unused, unopened blood to SFGH Blood Bank via courier. ~~(ask the nursing supervisor to assist)~~

**E. Resident Preparation**

1. The SNF physician informs the resident and family or SDM about the transfusion, and when and where it will take place.
2. The SNF neighborhood LN will provide a hand off to the PMA RN prior to sending the patient to PMA.
3. The SNF neighborhood physician will provide a hand off to the PMA physician including any information regarding previous transfusion reactions and any other pertinent information about current medical status and history.

Blood Product Administration ~~Transfusion: Appendix A~~

LHH Nursing Policies and Procedures

1.4. Standard precautions and any indicated enhanced precautions will be observed at all times.

2.5. In preparation for the transfusion, the PMA RN will complete the following: ~~The PMM7A RN nurse orients the resident to the unit and the transfusion procedure.~~

- a. Orients the resident to the unit and the transfusion procedure.
- ~~a.b.~~ If the resident is able to provide ~~relate~~ a reliable history, ask about previous transfusion reactions or allergies.
- c. Educates the resident about any changes or new signs and symptoms to report to the nurse during the transfusion.
- d. Performs resident physical assessment and documents on the nursing transfusion
- e. administration form, including vital signs (temperature, blood pressure, pulse, respiratory rate, and oxygen saturation) and other baseline body system assessments as appropriate (e.g., cardiovascular, respiratory, genitourinary, skin, intake and output)
- f. Administers any pre-medication as ordered.

~~a.~~ \_\_\_\_\_

3.6. Set up a 250 mL ~~ee~~ I.V. bag of Normal Saline with Y-blood tubing and in-line filter.

- a. Prime the tubing per manufacturer's directions ~~on the tubing package.~~
- ~~b.~~ Administer via CVAD, or obtain Start an I.V. access preferably with a 20G or larger bore I.V. catheter (preferable for blood
- ~~b.~~ transfusions to prevent hemolysis of red blood cells).
- c. ~~In the event of difficult venous access, may use 22 gauge IV catheter.~~ Use an I.V. infusion pump ~~approved for blood transfusion~~ to ensure steady flow and a controlled rate of infusion-
- ~~d.~~ Perform resident assessment and document on the nursing transfusion administration form, including full vital signs (temperature, blood pressure, pulse, respiratory rate, and oxygen saturation) and other baseline body system assessments as appropriate (e.g., cardiovascular, respiratory, genitourinary, skin, intake and output), ~~and prompted by the form.~~

**F. Verification Responsibility:**

~~1. 1.~~ Check the medical record for signed informed consent completed by the SNF physician.

~~1.~~ \_\_\_\_\_

~~2.~~ \_\_\_\_\_

~~3. 2.~~ Make sure the blood component matches the physician's order.

~~2.~~ \_\_\_\_\_

~~4.~~ \_\_\_\_\_

~~5. 3.~~ Two individuals (~~—~~either a Physician and RN, or 2 RN's) must identify the blood component and the resident at the bedside-

~~3.~~ \_\_\_\_\_

- a. Check the blood expiration date and compare the blood type, Rh type, and donor numbers on the blood bag label for matching information on the transfusion report form attached to the unit. **In an emergency, O-negative blood can be given to any resident. Rh negative blood can be given to an Rh positive resident.**
- b. Verify that the resident's first and last name and medical record number on the transfusion requisition and attached transfusion report form (unit tag) match.
- c. Check the resident's identification wristband for matching first and last name and hospital number against the information on the requisition and transfusion report form. Ask the

**Blood -Product Administration**~~Transfusion: Appendix A~~

LHH Nursing Policies and Procedures

resident to state his/her name and date of birth OR check the resident's photo in the medical record.

- d. Check the resident's identification wristband for matching first and last name and hospital number against the information on the requisition and transfusion report form. Ask the resident to state his/her name and date of birth OR check the resident's photo in the medical record.

**Note:** Make sure that all available identifying information on the requisition, unit tag, wristband and information provided by the resident him/herself match before proceeding with the transfusion

- e. If any discrepancies are identified:

- i. Do not begin transfusion.
- ii. Inform the physician
- iii. Notify the Blood Bank of the discrepancies and return the blood to SFGH Blood Bank via courier

- ~~6. Check the blood expiration date and compare the ABO, Rh type, and donor numbers on the blood bag label for matching information on the transfusion report form attached to the unit. **In an emergency, O-negative blood can be given to any resident. Rh negative blood can be given to an Rh positive resident.**~~

- ~~7. Verify that the resident's first and last name and hospital medical record number on the transfusion requisition and attached transfusion report form (unit tag) match.~~

- ~~8. Check the resident's identification wristband for matching first and last name and hospital number vis-à-vis against the information on the requisition and transfusion report form, and ask him/her the resident to state his/her name and date of birth of birth OR check the resident's photo in the medical chart record.~~

~~**Note:** Make sure that all available identifying information on the requisition, unit tag, wristband and information provided by the resident him/herself match before proceeding with the transfusion.~~

~~Do not begin transfusion if discrepancies are present.~~

~~Inform the physician.~~

- ~~a. Notify the Blood Bank of the discrepancies and return the blood to SFGH Blood Bank via courier.~~

- ~~9.4. If autologous or designated transfusion has been ordered, look for the extra tag attached to the unit signifying **aAutologous** (green tag) or **dDesignated donor** (orange tag).~~

- ~~10.5. \_\_\_\_\_ Inspect the blood product for clots, cloudiness, foaming or purplish/black color. If present, do not begin the transfusion. ~~Notify the SFGH Blood Bank and physician and document on the medical record.~~~~

- ~~11.6. \_\_\_\_\_ Both individuals who performed the resident/blood unit double-checks sign their names on the transfusion report which is attached to the unit of blood and which serves as attestation that it the unit is labeled for the intended resident (see back of form for signature and /double-check verification documentation).~~

- ~~7. The top copy of the signed transfusion report form is separated from the bottom copy and pasted in the resident's chart. The bottom copy must remain attached to the unit during the transfusion.~~

**G. Blood Administration**

Blood Product Administration~~Transfusion: Appendix A~~

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1. At the resident's bedside, before connecting the blood tubing, and before beginning administration of the blood product, starting the transfusion – a Physician and RN **OR** two RN's identify the blood product and the resident as detailed above under *Verification Responsibility*.
2. All nursing documentation is done on the M7PMA Nursing Blood Transfusion Administration record and the transfusion report attached to the blood product unit.
3. Obtain baseline vital signs prior to initiating the blood transfusion.
4. For each blood product unit, Vvital signs will be performed Q 15 minutes for the 1<sup>st</sup> hour; and then hourly thereafter.
5. The RN will remain at the resident's bedside for the 1<sup>st</sup> 15 minutes of the transfusion to monitor the resident's response and to assess for the signs and symptoms of a transfusion reaction.
  - a. During the 1<sup>st</sup> 15 minutes of transfusion, rate of infusion is slow: 1-2 mL↓ per minute.
  - b. If there are no signs of blood transfusion reaction, or intolerance-untoward side effects, the rate may be increased according to physician orders.
  - c. Recommended infusion time for one unit of PRBCs is 1.5-2 hours.
  - b.d. The transfusion must be completed within 4 hours because of the risk of bacterial contamination and red cell hemolysis.
6. If the resident develops an adverse reaction – STOP THE TRANSFUSION IMMEDIATELY and DISCONNECT THE BLOOD TUBING FROM THE I.V. OR CVAD PORT. NOTIFY THE PHYSICIAN. Document time of MD notification and resident's symptoms. Refer to Appendix A- Management of Blood Transfusion Reaction at the end of this P&P.
  - a. Set up new I.V. ~~blood administration~~-tubing and a new I.V. bag of 250 mL ~~0.9% NS~~. **DO NOT** discontinue I.V. access ~~catheter~~. Monitor vital signs and other signs/symptoms for a possible transfusion reaction.
  - b. Document transfusion reaction and all interventions in the medical record, Unusual Occurrence Report (if warranted), Transfusion Reaction Form, and nursing notes.
  - c. Save the tubing and blood unit bag – place in double plastic bag and send to SFGH Blood Bank
7. To prevent settling of blood components and help facilitate the flow, mix the cells and plasma by gently inverting the blood bag several times during the transfusion.
8. When the transfusion is completed, run 0.9% NS through the I.V. line to clear the tubing and then discontinue the I.V. unless resident needs a TKO line.
- 7.9. Complete documentation on all of the appropriate forms including time transfusion(s) were as complete, including intake and output.
10. Once the blood is discontinued, double bag the container and tubing and placed in the red infectious waste container.

#### H. Post transfusion Observations

1. The resident shall remain on M7PMA for up to at least 1 hour after transfusion has been completed. Vital signs will be taken hourly, as needed, and and just prior to transfer back to the SNF neighborhood~~home unit~~.
2. If vital signs are stable, resident may return to SNF neighborhood~~home unit~~.

**Blood -Product Administration** ~~Transfusion: Appendix A~~

LHH Nursing Policies and Procedures

3. Vital signs on the SNF neighborhood home unit will be performed once per shift for 48 hours or more often if indicated.

~~3.4.~~ The PMA RN will provide a hand off report to the SNF Licensed Nurse prior to sending the resident back to the SNF neighborhood.

**I. Documentation forms for blood transfusion:**

<u>Form:</u>	<u>Completed by:</u>
Informed consent	SNF MD
<del>PMA</del> <u>M7A</u> Blood Transfusion Record	
Top portion	SNF MD
Middle portion	<del>M7A</del> <u>PMA RN nurse</u>
Bottom portion	<del>PMA</del> <u>M7A</u> MD
Blood Transfusion Nursing Administration Record	<del>PMA</del> <u>M7A RN nurse</u>
Blood Product Delivery Receipt	<u>PMA RN n</u> <del>Nurse</del> who receives blood from the courier
Original signed computer copy attached to blood product	RN and MD or 2 RN's
<del>Unusual Occurrence Report</del>	<del>M7A MD and RN</del>
<del>(does not need to be completed for mild transfusion reactions – for these, completion of Transfusion Form is sufficient)</del>	
Blood Transfusion Reaction Form	<u>PMA</u> <del>M7A</del> MD

**APPENDICES:**

- Appendix A: Management of Transfusion Reaction
- Appendix B: SFHN Blood Transfusion Sticker
- Appendix C: SFHN Blood Bank Transfusion Requisition
- Appendix D: SFHN Blood Bank Transfusion Reaction Report Form
- Appendix E: SFHN Blood Bank Delivery Receipt for Blood and Blood Products
- Appendix F: SFHN Post-Transfusion Instructions
- Appendix G: SFHN ABO/Rh Compatibility Table
- Appendix H: LHH Transfusion Checklist
- Appendix I: Informed Consent Prior to Blood Transfusion and Counselling Form (pending approval)
- Appendix J: Blood Transfusion Adverse Reaction Reference
- Appendix K: Refusal to Permit Blood Transfusion (pending approval)
- Appendix L: Blood Transfusion Forms:
  - PMA A Blood Transfusion Record (MR # 116)
  - PMA ~~Pre-printed~~ Preprinted physician order sheet (MR # 168)
  - PMA Nursing Blood Transfusion Administration Record (MR #354)
  - PMA Post transfusion Instructions
  - Resident Care Plan for Blood Transfusion

**REFERENCES:**

- Lippincott, Williams & Wilkins, 2<sup>nd</sup> Edition, Best Practices: Evidenced Based Nursing Procedures. (2007)
- San Francisco General Hospital and Trauma Center: Blood Bank Policies and Procedure 2007

**Blood -Product Administration**~~Transfusion: Appendix A~~

*LHH Nursing Policies and Procedures*

**CROSS REFERENCES:**

LHHPP File # \_\_\_\_\_ Informed Consent Prior to Blood Transfusion and Counselling of Patient ~~To Forms used:~~

~~PMA M7A Blood Transfusion Record (MR # 116)~~

~~PMAM7A Pre-printed physician order sheet (MR # 168)~~

~~PMAM7A Nursing Blood Transfusion Administration Record (MR #354)~~

~~PMAM7A Post transfusion Instructions~~

~~Resident Care Plan for Blood Transfusion~~

SFGH Blood Bank Requisition (5788120-Rev 2/05)

SFGH Blood Bank Delivery Receipt

SFGH Blood Bank Blood Transfusion Report (5711101 f111 (2/00)

SFGH Blood Transfusion Reaction Report Form (5793499, f934-Rev8/05)

~~Document r~~Revised: 8/2000; 9/2008; 02/2015; 10/23/2015

Reviewed: \_\_\_\_\_

Approved: \_\_\_\_\_

**APPENDIX:**

A. ~~Blood Transfusion Reaction Management:~~

**Blood Transfusion: Appendix A: Management of Transfusion Reaction LHH****RELEVANT INFORMATION:**

Transfusion reactions are defined as any adverse reaction to blood products. Less than 10cc of incompatible product may cause a severe reaction. Residents with a history of previous transfusion reaction have a greater chance of reaction with future transfusions. Careful observation through presenting symptoms of fever and chills may be the same for a life-threatening reaction and a less serious febrile reaction. Definition of a febrile reaction is a rise of  $> 1^{\circ}$  C in temperature from the pre transfusion temperature.

**PROCEDURE:**

## 1. Observe resident closely for the following signs and symptoms:

- |                         |                         |
|-------------------------|-------------------------|
| a. chills               | i. pruritis             |
| b. fever                | j. urticaria            |
| c. anxiety              | k. hypotension          |
| d. dyspnea              | l. headache             |
| e. chest tightness/pain | m. nausea               |
| f. back pain            | n. flushing             |
| g. shock                | o. oliguria             |
| h. hemoglobinuria       | p. generalized bleeding |

2. Take the following immediate action at the 1<sup>st</sup> signs/symptoms noted above:

- a. STOP THE TRANSFUSION. Clamp the tubing; change IV administration set. Keep IV line open with 250cc 0.9 % NS
- b. Notify MD and Nursing Supervisor
- c. Check all labels, forms, and resident identifications to determine whether the resident received the correct blood. Save the blood bag and IV tubing.
  - i. Discontinuing the transfusion is based upon whether there are any signs of a potentially life threatening transfusion reaction (i.e. anaphylactic shock, intravascular hemolysis, sepsis or pulmonary edema. In general transfusion associated with febrile reactions should be discontinued and investigated, unless the fever can be clearly attributed to a cause unrelated to transfusion. The decision to continue with the transfusion has to be made by the responsible physician after assessing the resident.)
  - ii. If the resident has had previous mild allergic reactions, the physician may choose to continue the transfusion and give an antihistamine, i.e. diphenhydramine (Benadryl).
  - iii. Take complete vital signs and temperature at the beginning of the reaction and document; continue vital signs Q 15 minutes until vital signs stabilize. Monitor strict I/) (Q1hour); send 1<sup>st</sup> urine specimen to the lab.
  - iv. Collect a 10 ml pink top tube for transfusion reaction work-up. Label the blood sample at the bedside in the presence of the resident.
  - v. Place the disconnected blood bag and IV tubing in a double plastic bag and ask the Nursing Supervisor to arrange for a courier to pick up the blood bag, transfusion reaction blood sample and completed transfusion form (to be completed by the physician, see below) for delivery to the SFGH Blood Bank.

## 3. Physician must complete and sign the Blood Bank Transfusion Reaction



Report form (5793400, F394). Place "pink" preliminary report in the resident's chart and send the original white copy and yellow copy with the lab specimens and blood bag. (Once the investigation is completed, the original form will be returned to the resident's chart).

### 3. Nursing Documentation

- a. All actions taken in response to the transfusion reaction will be documented on the nursing blood administration form (medications, resident signs/symptoms, strict I/O, notification of MD and Nursing Supervisor, etc)
- b. Acute transfusion reactions, presenting with fever, shortness of breath, hypo or hypertension, aches and pains, rash or gastrointestinal symptoms may become manifest up to 8 hours after the transfusion. A delayed reaction typically presents 3-7 days (up to 14-21 days) post transfusion with signs/symptoms of falling hemoglobin, rarely oliguria, anuria, hemoglobinuria, jaundice. Therefore the resident should be monitored on the home unit for the first 48 hours after transfusion for possible acute reactions, and (optionally) 5-7 days after transfusion for a possible delayed reaction (hemoglobin check).

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**Blood Transfusion: Appendix A: Management of Transfusion Reaction LHH****RELEVANT INFORMATION:**

Transfusion reactions are defined as any adverse reaction to blood products. Less than 10cc of incompatible product may cause a severe reaction. Residents with a history of previous transfusion reaction have a greater chance of reaction with future transfusions. Careful observation through presenting symptoms of fever and chills may be the same for a life-threatening reaction and a less serious febrile reaction. Definition of a febrile reaction is a rise of  $> 1^{\circ}$  C in temperature from the pre transfusion temperature.

**PROCEDURE:**

1. Observe resident closely for the following signs and symptoms:
  - a. chills
  - b. fever
  - c. anxiety
  - d. dyspnea
  - e. chest tightness/pain
  - f. back pain
  - g. shock
  - h. hemoglobinuria
  - i. pruritis
  - j. urticaria
  - k. hypotension
  - l. headache
  - m. nausea
  - n. flushing
  - o. oliguria
  - p. generalized bleeding
2. Take the following immediate action at the 1<sup>st</sup> signs/symptoms noted above:
  - a. STOP THE TRANSFUSION. Clamp the tubing; change IV administration set. Keep IV line open with 250cc 0.9 % NS
  - b. Notify MD and Nursing Supervisor
  - c. Check all labels, forms, and resident identifications to determine whether the resident received the correct blood. Save the blood bag and IV tubing.
    - i. Discontinuing the transfusion is based upon whether there are any signs of a potentially life threatening transfusion reaction (i.e. anaphylactic shock, intravascular hemolysis, sepsis or pulmonary edema. In general transfusion associated with febrile reactions should be discontinued and investigated, unless the fever can be clearly attributed to a cause unrelated to transfusion. The decision to continue with the transfusion has to be made by the responsible physician after assessing the resident.)
    - ii. If the resident has had previous mild allergic reactions, the physician may choose to continue the transfusion and give an antihistamine, i.e. diphenhydramine (Benadryl).
    - iii. Take complete vital signs and temperature at the beginning of the reaction and document; continue vital signs Q 15 minutes until vital signs stabilize. Monitor strict I/) (Q1hour); send 1<sup>st</sup> urine specimen to the lab.
    - iv. Collect a 10 ml pink top tube for transfusion reaction work-up. Label the blood sample at the bedside in the presence of the resident.
    - v. Place the disconnected blood bag and IV tubing in a double plastic bag and ask the Nursing Supervisor to arrange for a courier to pick up the blood bag, transfusion reaction blood sample and completed transfusion form (to be completed by the physician, see below) for delivery to the SFGH Blood Bank.
3. Physician must complete and sign the Blood Bank Transfusion Reaction Report form (5793400, F394). Place "pink" preliminary report in the resident's chart and send the original white copy and yellow copy with the lab specimens and blood bag. (Once the Investigation is completed, the original form will be returned to the resident's chart).

3. Nursing Documentation

- a. All actions taken in response to the transfusion reaction will be documented on the nursing blood administration form (medications, resident signs/symptoms, strict I/O, notification of MD and Nursing Supervisor, etc)
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## **VOLUNTEER RECRUITMENT PROCESS LIFE CYCLE**

### **POLICY:**

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center is responsible for the full business life cycle of volunteers, including recruitment, placement, encouragement and retention, and dismissal.

### **PURPOSE:**

1. To outline formal steps involved in developing a general pool of volunteers available to the hospital.
2. To meet the specific human resource needs of hospital departments requesting the assistance of Volunteer Services Department.
3. To ensure that hospital residents receive the highest quality volunteers to provide companionship and support.

### **PROCEDURE:**

#### **Volunteer Recruitment**

1. Friends of Laguna Honda Website
  - a. Friends of Laguna Honda (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.
2. Outreach
  - a. The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.
  - b. When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.
3. Media
  - a. The Volunteer Services Department and Friends of Laguna Honda may utilize Public Service Announcements written and electronic media for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.
4. Volunteer Organizations
  - a. The Volunteer Services Department maintains listings of volunteer opportunities at Laguna Honda Hospital with local community volunteer

organizations such as the San Francisco Volunteer Center and Hands on Bay Area.

## **Volunteer Placement**

1. Orientation
  - a. Each prospective volunteer is required to participate in the volunteer orientation prior to placement.
  - b. At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.
  - c. Each volunteer is required to complete a volunteer application prior to the interview.
2. The Interview
  - a. Content of the interview include:
    - i. Review information on the application
    - ii. Visual inspection of a picture ID
    - iii. Reasons and motivations for doing volunteer work
    - iv. Discussion of areas of interest and hospital placement need
    - v. Review abuse reporting policy and sign form
    - vi. Review volunteer agreement and sign form
    - vii. Review statement of privacy laws and acknowledgement of responsibility and sign form
    - viii. Arrangements for TB test, ID badge, and parking permit
    - ix. Criminal background check and fingerprinting
  - b. During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.
  - c. The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department of where he/she will volunteer in.
  - d. The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.
  - e. A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.
3. Placement
  - a. The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident involved.
  - b. Volunteers are assigned a supervising staff member from the department in which they are placed. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators assumes responsibility for supervision of the volunteer.
  - c. The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) in the specific department he/she is interested in. The POC and the volunteer will then further discuss logistics

- (commitment, time, schedule, etc.) to finalize placement. Occasionally the Volunteer Coordinator may not be available at the proposed meeting time, and may arrange a meeting between the volunteer and supervising staff member.
- d. Number of hours per week or month is negotiated between the volunteer and the supervising staff member in consideration of the needs of the activity, neighborhood, resident, and the availability of the volunteer.
  - e. The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes.
  - f. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).
4. The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.

### **Encouragement and Retention**

1. The Volunteer Services Department, in conjunction with Friends of Laguna Honda, take actions during the annual National Volunteer Week in April to express appreciation toward all volunteers.
  - a. These actions may include an appreciation luncheon/dinner or other similar event.
  - b. Banners or posters will be displayed throughout the hospital recognizing National Volunteer Week.
2. The appreciation Luncheon/dinner will recognize volunteers for the number of cumulative hours served, and the number of years given in service.
  - a. Certificates will be awarded with the total number of volunteer hours as of April 1st. These certificates are signed by the president of Friends of Laguna Honda.
  - b. Service pins are awarded to Volunteers with the following years of service
    - i. Five years
    - ii. Ten years
    - iii. Fifteen years
    - iv. Twenty years
    - v. And so on in increments of 5 years
3. Each Volunteer Coordinator and Spiritual Care Coordinator chooses an individual or group to be recognized at the event called "Special Awards". These awards are based on the Coordinator's discretion for their commitment to ongoing volunteer service and who feel have made a significant impact on the hospital.
- ~~3.4.~~ Volunteers who are on duty during the day are entitled to a 50% discount at the hospital's cafeteria for one meal during their shift.

- a. Volunteers must show their volunteer identification badge to the cashier to receive the discount.
- 4.5. Thank You Cards will be sent to individual volunteers to recognize those who help above and beyond the call of duty (i.e., special events volunteers, special projects, Holiday Program and those who come in on days they are not scheduled).
- 5.6. Volunteer Coordinators will make an effort to respond to volunteer questions, concerns or needs in a timely manner.

### **Volunteer Dismissal**

Volunteers who do not adhere to the policies and procedures of the program or who fail to satisfactorily perform their volunteer assignment are subject to dismissal. At the discretion of the Volunteer Coordinator, any volunteer not meeting the requirements of what was agreed upon in their application can be dismissed at any given time.

### **Corrective Action**

Corrective/ disciplinary action may be taken if the volunteer's work is unsatisfactory. The procedure for disciplinary action is a three step process.

1. First a formal written notice is sent to the volunteer.
2. Second formal notice is sent and a meeting with the volunteer, their supervisor from the area they volunteer and the Volunteer Coordinator is set up.
3. Notice to the volunteer of dismissal of their duties. The volunteer will be responsible to turn in their ID Badge and a parking permit (if they have one).

Conduct or behavior which may lead to disciplinary action includes, but is not limited to:

- Poor Timekeeping and or unreliability of their time.
- Not following rules, policies as described in the Orientation Packet
- Rudeness or hostility towards, residents, staff or other volunteers.
- Intoxication through alcohol or other illegal substances
- Theft of property or compensation for assisting residents
- Failure to perform volunteer duties as agreed
- Bringing illegal substances in to the hospital
- Breach of confidentiality
- Falsification of any materials

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Revised: 2015/20/03, [2015/08/19](#), [2016/07/12](#)

Original Adoption: 1998/06/01



## **VOLUNTEER ORIENTATION REGISTRATION**

### **POLICY:**

The Volunteer Services Department will register all prospective volunteers for an orientation via the Friends Of Laguna Honda website ([lagunahondavolunteers.org](http://lagunahondavolunteers.org)), via [email: volunteers@sfdph.org](mailto:volunteers@sfdph.org) or via telephone.

### **PURPOSE:**

To provide potential volunteers an opportunity to sign up for an orientation through various channels.

### **PROCEDURE:**

1. Volunteer Coordinators ~~(VC)~~ will be responsible to screen and review all incoming calls from the Volunteer general phone line (415.759.3333) to register probable volunteers on a daily basis. The VC will also be assigned to check the general Volunteer email ([volunteers@sfdph.org](mailto:volunteers@sfdph.org)) to register future volunteers.
2. The Friends ~~o~~f Laguna Honda website ([lagunahondavolunteer.org](http://lagunahondavolunteer.org)) is linked with the email address ([volunteers@sfdph.org](mailto:volunteers@sfdph.org)) therefore when a prospective volunteer signs up for an orientation through the website, it will automatically appear on the email. Prospects signing up for a volunteer orientation online will receive a volunteer confirmation email (regarding time, date, location, etc.) and volunteers who phoned will receive a verbal confirmation.
3. The Volunteer Coordinator~~VC~~ will enroll potential volunteers in the ~~o~~orientation registration book ~~(located in the Volunteer lounge)~~ and will stop enrolling volunteers when there are ~~250~~ attendees for an orientation.
4. The Volunteer Coordinator~~VC~~ will recommend other orientations as there are 2 orientations each month for prospects when enrollment has reached its maximum capacity.

~~The VC is responsible for calling and reminding volunteers of the orientation to confirm their attendance.~~

### **ATTACHMENT:**

None

**REFERENCE:**

None

Most Recent Review:~~12/~~  
12/08/17, 2016/06/20

## ~~INFECTION CONTROL~~ VOLUNTEER INFECTION PREVENTION

### **POLICY:**

The Volunteer Services Department will comply with infection control policies established by the Infection Control Committee and Medical Staff at LHH.

### **PURPOSE:**

To protect the health of residents, employees and their families, volunteers, and visitors by preventing the transmission of tuberculosis, influenza and other infectious diseases.

### **PROCEDURE:**

1. All volunteers receive instruction about infection control at the volunteer orientation.
  - a. Topics covered include:
    - i. Hand washing
    - ii. Standard precautions related to bodily fluids
    - iii. Staying away from LHH when a volunteer is ill.
2. All new volunteers are required to have a 2-step T.B. Tuberculosis/ PPD skin test (~~PPD~~) prior to beginning their volunteer service at the hospital.
  - a. Volunteers may get the Tuberculosis test at the Laguna Honda Medical Clinic or with their own provider.
  - b. If a volunteer has documentation of a prior PPD negative test that was completed within a year, it's considered valid.
- ~~3.~~
- ~~4.3.~~ 3. When having TB testing administered at the Medical Clinic, the volunteer will examine skin for any visible reaction in approximately 48 – 72 hours after the test. If there is no reaction, the volunteer will return to the Medical Clinic the following week for a second test. The volunteer will then return within 48 – 72 hours (2 days) for a second reading. If ~~the~~ test is negative, the volunteer is cleared to begin their volunteer service.
4. If a volunteer has a positive reaction to the T.B. test, they may be able to ~~ey will~~ receive a chest x-ray (if they are a resident of San Francisco) at San Francisco General Hospital ~~FGH~~. If they are not a resident of San Francisco, he/ she will need to go to their county hospital or private physician. The results are to be sent ~~sent~~ to the Laguna Honda Hospital Medical Clinic along with the T.B. symptom questionnaire.

- Volunteers having a positive reaction who do not reside in San Francisco will be counseled to get follow up at their county health department. Those volunteers must provide documentation that they do not have active T.B. before being allowed to begin volunteer work at Laguna Honda.
  - Any volunteer determined to have active T.B. are referred to the Department of Health of their county which they reside in for further advice/action.
5. All active volunteers will be required to receive an annual tuberculosis screening. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptom review for those with prior positive skin tests.
  6. Documentation of all PPD tests will remain in the Medical Clinic. ~~Documentation of volunteers that are no longer active and are a year old will be discarded.~~ The clinic will maintain all volunteer documentation and create a spreadsheet of those that are still active and contact the Volunteer Services Department for those that are due for yearly testing.
  7. Volunteers who fail to get an annual T.B. test will be contacted by Volunteer Services and not be allowed to return until he/she receives a T.B. test.
  8. All volunteers are required to comply with the hospital's Influenza Vaccination policy on an annual basis.
    - a. Volunteers are required to get an influenza vaccination by the beginning of flu season as identified by the hospital's Infection Control Committee.
      - i. If available, volunteers are able to get the vaccinations at Medical Clinic.
      - ii. If there ~~is no vaccination~~ ~~e-not~~ available at the hospital, the volunteer must get a vaccination from their provider and submit proof of vacation to the Medical Clinic.
    - b. Volunteers who have received an influenza vaccination will be provided with a sticker to be placed on the ID badge which will allow them access to resident areas during flu season.
    - c. Volunteer choosing not to get an influenza vaccination must sign a declination form.

- i. During the flu season, if a volunteer chooses not to get a vaccination, he/she must wear a mask when in a resident area or within 3 feet of a resident.

**ATTACHMENT:**

None

**REFERENCE:**

LHHPP 72-01 Infection Control Manual

LHHPP 72-04 Employee Annual Health Examination ~~05 Employee Vaccination Policy~~  
Volunteer Services policy A 1.0 Volunteer Orientation

Revised: 2014/06/09, 2015/08/19, 2016/06/20 2007/12

Original Adoption: 2012/08/14

## **RESIDENTS WITH GENERALIZED RASHES**

### **POLICY:**

To reduce the risk of transmission of chickenpox, measles, rubella and other infectious diseases in the facility, residents, and personnel with generalized rashes will be segregated from others.

### **PURPOSE:**

The Infection Control Program at Laguna Honda Hospital has adopted measures to reduce transmission of infectious disease to residents, visitors and staff.

### **PROCEDURE:**

1. LHH staff persons will be alert to residents listing symptoms that include rash, or to visualizing a rash on a resident or persons accompanying the resident.
2. Persons with an acute generalized rash that contains blisters or viscous fluid should be separated from other patients, placed in a private room and asked to wear a surgical mask. Also, patients with bleeding or purpuric rashes should be isolated. A negative pressure room should be used if available. A clinician should be notified immediately to evaluate the patient. Persons entering the room should wear an appropriate N95 mask.
3. If resident's family or household member has a confirmed diagnosis of chickenpox, measles or rubella, the resident should be isolated in a room and disallowed in the unit or hallways until determined to be not contagious by clinical staff.

### **ATTACHMENT:**

None.

### **REFERENCE:**

None.

Original adoption: 05/11/01 (Year/Month/Day)

## **ANNUAL /PERIODIC HEALTH ASSESSMENT**

### **POLICY:**

Health assessments are required on an annual basis for all personnel who work at Laguna Honda Hospital (LHH) on a continuing basis.

### **PURPOSE:**

To reduce the potential for disease transmission from personnel to residents and to assess possible transmission from residents to personnel, regular health assessments are performed.

**Personnel are defined as employees of Laguna Honda Hospital, volunteers, students, medical staff, and contracted personnel working within the facility on a continual basis.**

### **PROCEDURE:**

1. The annual health assessment for all personnel includes the following:
  - a. Tuberculosis screening including PPD skin testing for those PPD negative, and a TB symptom review for those PPD positive, will be done every six or twelve months, depending on occupational exposure risk.
  - b. Compliance with scheduled TB screening is expected. Health care workers (HCWs) will receive a notification from the LHH Clinic when his or her annual PPD test or TB screening is due. A list of staff who are due for completing this annual requirement will be sent by the designated LHH Clinic nurse to department managers each month. Department managers are responsible for follow up on annual health requirement non-compliances reported to them. HCWs who are non-compliant for their annual PPD test or TB screening will be followed up according to Human Resources protocols.
  - c. Annual evaluations of immunization needs are assessed on a case-by-case basis. Non-immunized personnel are offered the Hepatitis B, influenza (in season), tetanus/ diphtheria, and varicella vaccines as necessary.
2. Documentation is maintained within the Employee Health Service.
3. Compliance is reported to the Infection Control Committee not less than annually.
4. Annual physical assessments are required for all personnel working at LHH Skilled Nursing Facility (SNF) in accordance with California Title 22 regulations.

5. Annual respirator/medical surveillance physical assessments are required for designated plant service employees on the Disaster Response Team.

**ATTACHMENT:**

None.

**REFERENCE:**

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: 16/03/08 (Year, Month, Day)

Original adoption: Est. 05/11/01



## **ANNUAL EMPLOYEE PPD TESTING**

### **POLICY:**

All employees of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) are required to participate in the Tuberculosis Surveillance Program.

### **PURPOSE:**

This program is designed to protect the health of patients, employees and their families by preventing the transmission of tuberculosis and to comply with state licensure requirement of Title 22, paragraph 70723, Section 208(a) and Health and Safety Code, Section 1275 (also reference: Health and Safety Code, Section 1276).

### **IMPLEMENTATION PROCEDURE:**

Refer to Laguna Honda Infection Control Manual, Employee Health section for detailed procedures.

1. All new employees will be given a two-step PPD skin test unless medical reasons exist to give no such test. The Medicine Clinic at San Francisco General Hospital (SFGH) or the Outpatient Clinic at LHH will document the PPD administration or reason for not completing it.
2. The PPD skin test results will be maintained in the Employee Health records at Laguna Honda Outpatient Clinic.
3. All employees shall receive annual tuberculosis screening at Laguna Honda. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptom review for those with prior positive skin tests.
4. Employees who convert their skin tests will receive a TB Symptom Review Survey, chest x-rays and referral to the Tuberculosis Clinic at SFGH. The results of the evaluation from the SFGH Tuberculosis Clinic will be sent to the Laguna Honda Outpatient Clinic. The Medical Director or Designee will review these results and provide the clearance for the employee to continue work.

**ATTACHMENT:** None

### **REFERENCE:**

LHHPP 72-04 Employee Annual Health Examination

Revised: 98/04/01, 12/09/25, 15/01/13 (Year/Month/Day)

Original adoption: 96/07/15

Approved for renumbering from 72-03 to 73-12: 15/01/13

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## OVERDUE RECORD

### RETRIEVAL OF MEDICAL RECORDS:

#### POLICY:

1. To ensure the retrieval of all overdue medical records (protected health information) from requestors that has not been returned to the Health Information Services Department as scheduled.

#### PURPOSE:

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

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#### PROCEDURE:

##### I. RETRIEVAL OF MEDICAL RECORDS

- A) The medical records (P.H.I.) of discharged patients must be received by the Health Information Services Department within 48 hours of discharge in order for Health Information personnel process the record.
- B) Medical records of discharged patients include the contents of the rack chart, thinned protected health information, and any other loose documents.
- C) Discharge records are not to be removed from the unit from which the patient/resident was discharged, by anyone other than a HIS employee.

##### II. CHART REQUESTS

- A) Health Information personnel are available, Monday thru Fridays, between the hours of 8:00 a.m. - 5:00 p.m., with an exception of Legal Holidays that the HIS Department is closed.
- B) **All medical records** requested and delivered from the Health Information Services Department must be returned to the HIS department **within 72 hours**.
- C) The Health Information Services Department will run the Overdue List report in Chart Locator Module of the Nuance System, on a daily basis to identify records out to requestors beyond 72 hours.
- D) HIS will contact the requestor, identified on the report, and state that the record must returned to the HIS Department or the record will be picked up by a HIS employee.
- E) HIS perform a chart sweep to the units to pick-up all overdue records and locate missing records.

### III. MISSING RECORDS

- F) If the record(s) is missing the HIS employee will complete the Health Information Services Department Missing Records form.
- G) The HIS Employee will call or email the Person identified in the Chart Locator System as the most recent requestor who received the record(s).
- H) If the requestor indicates that the records was given to another person, the HIS employee will document the name of the person, unit/department for this person and make contact to retrieve the record(s).
- I) If on the fourth day after the record(s) was due to be returned to the HIS Department and the record is still unaccounted for, an email will be sent to the last requestor on the Overdue List report. This information will be documented on the Health Information Services Missing Record Form and provided to HIS Management. The HIS staff will be alerted to check the units for the missing record(s) and report back to HIS Management.
- J) On day five, HIS Management will email the Privacy Officer and the Quality Management Director with notification of missing record(s). The HIS staff will be alerted to check the units for the missing record(s) and report back to HIS Management.
- K) On day ten, HIS will complete the Unusual Occurrence form (UO Form). The HIS staff will be alerted to check the units for the missing record(s) and report back to HIS Management.
- L) If the record(s) are found, the bottom section of the Health Information Services Department Overdue Form will be completed with the identification of the person who had possession of the record(s), the department where the record(s) were located and the date.
- M) HIS Management will notify the Privacy Officer and Quality Management Director of the locating and retrieval of the missing record(s).

### IV. OVERDUE RECORDS

- N) If the requestor fails to return the record(s) and record(s) is not located on the units, a HIS employee will complete the Health Information Services Department Overdue Record Form.
- O) If on the fourth day after the record(s) was due to be returned to the HIS Department and the record is still unaccounted for, an email will be sent to the last requestor on the Overdue List report informing the requestor that they have medical records that are overdue for return to the HIS department. This information will be documented on the Health Information Services Overdue Record Form and provided to HIS Management. The HIS staff will be alerted to check the units for the overdue record(s) and report back to HIS Management.
- P) On day five, the HIS employee will complete the Health Information Services Missing Record Form and provided to HIS Management. HIS Management will email the Privacy Officer and the Quality Management Director with notification of missing record(s). The HIS staff will be alerted to check the units for the missing record(s) and report back to HIS Management.
- Q) On day ten, HIS will complete the Unusual Occurrence form (UO Form). The HIS staff will be alerted to check the units for the missing record(s) and report back to HIS Management.

- R) If the record(s) are found, the bottom section of the Health Information Services Department Missing Form will be completed with the identification of the person who had possession of the record(s), the department where the record(s) were located and the date.
- S) HIS Management will notify the Privacy Officer and Quality Management Director of the locating and retrieval of the missing record(s).

DRAFT

Most recent review: /2015  
Revised:  
Original Adoption: