

## List of Hospital-wide/Department Policies & Procedures Submitted to JCC for Approval on November 8, 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 22-11	<b>Patient/Resident Freedom from Abuse on Social Media Policy</b>	Created to support the effective and responsible use of social media.
LHHPP 27-06	<b>Guidelines for Inpatient Rehabilitation Facility Documentation</b>	Created to establish protocol for assessment and documentation of patients admitted to the Pavilion Mezzanine Acute Rehabilitation unit.
LHHPP 50-11	<b>Procurement Card</b>	Created to ensure a process for the utilization of a procurement card.
<b><u>b. New Department Policies and Procedures</u></b>		
<i>Department: Nursing</i>		
<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
NPP M 3.0	<b>Medi-Therm II Hyper/Hypothermia Machine</b>	New policy to address the use of the Gaymar Medi-Therm II Hyper/Hypothermia Machine (not to be used solely for comfort).
<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 20-09	<b>Short Stay</b>	Clarification of the bi-monthly hospital-wide short stay review meeting by Social Services Director and the Patient Flow Coordinator.
LHHPP 22-01	<b>Abuse Prevention, Identification, Investigation and Response</b>	Clarification that an independent investigation of abuse allegation involving Registry staff will be conducted by the CNO.
LHHPP 22-06	<b>Residents' Council</b>	Inclusion of the Resident Council Bylaws as an appendix.
LHHPP 23-01	<b>Resident Care Plan, Resident Care Team &amp; Resident Care Conference</b>	Clarification of nursing assistant and assigned licensed nurse role in the Resident Care Conference.
LHHPP 24-07	<b>Visiting Hours</b>	Clarification that visiting hours are recommended times and visitors must check in upon arrival.
LHHPP 24-10	<b>Coach Use for Close Observation</b>	Title change from <i>Close Observation</i> to <i>Coach Use for Close Observation</i> . Clarification of the role and expectations of the Coach.
LHHPP 25-07	<b>Antimicrobial Stewardship Program</b>	Revision of policy to include targeted antimicrobial prescriptions on the SNF units.
LHHPP 29-06	<b>Caring for the Deceased, Use of Morgue, and Provision of Death Certificates</b>	Inclusion of a procedure regarding morgue monitoring.

LHHPP 45-01	<b>Gift Fund Management</b>	Update of reimbursement process, reimbursement request forms, and budgetary planning processes.
LHHPP 55-01	<b>Medicare Part A Eligibility, Certification and Coverage</b>	Title change to <i>Payor Eligibility Certification and Coverage</i> . Revision of determination procedures for primary payor certification and coverage.
LHHPP 55-02	<b>Processing of Long Term Care Treatment Authorization Requests</b>	Updated to reflect new Electronic Treatment Authorization Request (eTAR) policies and procedures.
LHHPP 55-03	<b>Pre-Admission Screening and Resident Review (PASRR)</b>	Revision of the procedure for PASRR completion and completion of a level II referral to DMH that will be electrically uploaded to the EHR system.
LHHPP 73-06	<b>Bloodborne Pathogen Exposure Control Plan</b>	Revision of the policy and purpose of the BBP plan.
LHHPP 73-07	<b>Aerosol Transmissible Disease Exposure Control Plan</b>	Revision of the procedure for transferring residents requiring airborne isolation; and the steps necessary for exposure incident follow-up.
LHHPP 75-03	<b>Disorderly or Disruptive Visitors</b>	Clarification that visiting hours are recommended times.
LHHPP 75-10	<b>Appendix H Visitors Screening Process</b>	Clarification that visiting hours are recommended times. Process provided for visitor screening and authorization procedures.

**b. Revised Department Policies and Procedures**

***Department: Nursing***

<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
NPP F 5.0	<b>Nursing Management of Urinary Catheters</b>	Included section on "Urinary Catheter Care Maintenance for Aquatic Services."
NPP F 7.0	<b>Replacement and Care/Maintenance of an Existing Suprapubic Catheter</b>	Included section on "Suprapubic Catheter Maintenance for Aquatic Services." Added Catheter Plug with Cap under equipment list.

***Department: Pharmacy***

<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Revision</b>
Pharm 02.01.06	Expiration Dating of Pharmaceuticals	Revision of the procedure for multi-dose vials of injectables that contain preservative.

**3. a. Hospital-wide Policies and Procedures for Deletion**

<b>Policy Number</b>	<b>Title</b>	<b>Comments/Reason(s) for Deletion</b>
None.		

## **PATIENT/RESIDENT FREEDOM FROM ABUSE ON SOCIAL MEDIA**

### **POLICY:**

1. The Patient/Resident Freedom from Abuse on Social Media policy provides guidance to Laguna Honda Hospital (LHH) staff regarding a patient's and/or resident's right to personal privacy and dignity of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care.
2. Taking photographs or recordings of a patient and/or resident and/or his/her private space without the patient's, resident's, or designated representative's written consent, is a violation of the individual's right to privacy and confidentiality.
3. Posting photographs or recordings of a patient and/or resident and/or his/her private space that demean or humiliate a resident is mental abuse and is prohibited even if the patient, resident, or designated representative granted verbal or written consent.

### **PURPOSE:**

It is the intent of this policy to support the effective and responsible use of social media, protect the privacy and dignity of Laguna Honda patients, residents, and staff and to ensure compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and State privacy regulations.

### **DEFINITION:**

For the purpose of this policy LHH staff includes employees, consultants, contractors, volunteers, and other caregivers who provide care and services to patients and residents on behalf of the facility.

### **PROCEDURE:**

1. Protecting Patient/Resident Privacy – Prevention of Abuse on Social Media
  - a. Abuse Prohibition
    - i. A photograph or recording of a patient and/or resident that demeans or humiliates the individual, regardless of whether the patient and/or resident provided consent and regardless of the patient's and/or resident's cognitive status is mental abuse.
      - Photographs or recordings that demean or humiliate include photographs and recordings of patients and/or residents that contain nudity, sexual and intimate relations, bathing, showering, toileting, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the patient and/or resident,

showing a body part without the individual's face whether it is the chest, limbs, or back, labeling patient's and/or resident's pictures and/or providing comments in a demeaning manner, directing a patient and/or resident to use inappropriate language, and showing the patient and/or resident in a compromised position.

- i. LHH Staff shall not take or use photographs or recordings in any manner that demean or humiliate a patient or resident.
  - ii. LHH staff shall not keep, distribute, or post a photograph or recording, or link to a photograph or recording, in any format including on social media that demeans or humiliates a patient and/or resident is prohibited.
  - iii. LHH staff shall not post statements that demean or humiliate a patient/resident on social media.
- b. If an employee sees social media posting(s) that demeans or humiliates a patient/resident as described in Procedure 1, the employee is responsible for reporting such posting to their supervisor or to the Quality Management department, and submit an Unusual Occurrence report.
- c. Protecting Patient/Resident Confidentiality
- i. LHH employees shall comply with all LHH and San Francisco Department of Public Health (SFDPH)-wide policies regarding the confidential information of a patient/resident and relating to the use of social media, including LHHPP 21-01 Medical Records Information: Confidentiality and Release; LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response; SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI); and SFDPH HIPPA Compliance – Social Media Policy.

## 2. Compliance

- a. DPH and LHH reserve the right to request to have online communications stop if DPH or LHH believe communications from an employee, physician, fellow, patient, resident, volunteer, and/or students are in violation of organizational policies, values or local, state or federal laws privacy laws.
- b. Violations of this policy shall be reported to the Compliance Office and to the Quality Management department.
- c. Violations shall be investigated to determine the nature, extent and potential risk to the hospital. Refer to LHHPP 22-01: Abuse Prevention, Identification, Investigation and Response for investigation procedures.

- d. All LHH Staff who witness or are informed of a violation of this policy, including suspected abuse as clarified in this policy, shall follow the protection and reporting protocols, and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.
  
- e. All LHH Staff who violate this policy shall be subject to the investigation protocol and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 22-01: Abuse Prevention, Identification, Investigation and Response

CMS Survey & Certification: 16-33-NH

SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI)

SFDPH HIPPA Compliance – Social Media Policy

Original adoption: 16/11/08 (Year/Month/Day)

## **GUIDELINES FOR INPATIENT REHABILITATION FACILITY DOCUMENTATION**

### **POLICY:**

1. Patients who are admitted to the Pavilion Mezzanine Acute Rehabilitation unit (PMR), which is designated as an Inpatient Rehabilitation Facility (IRF), will have required assessment and documentation completed in a timely manner.
2. Interdisciplinary Team (IDT) members are responsible for the timely completion of patient assessment, evaluation and progress note documentation for their respective disciplines at admission, discharge and throughout the acute rehabilitation patient's stay.
3. The medical records of all patients admitted to the Pavilion Mezzanine Acute Rehabilitation unit (IRF) must contain documentation that reflects the patients' need for admission and ongoing need for intensive rehabilitation delivered by an interdisciplinary team.
4. All Medicare A patients admitted to the Pavilion Mezzanine Acute Rehabilitation unit (IRF) will have an Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) completed electronically at admission and discharge.

### **PURPOSE:**

1. To guide the Pavilion Mezzanine Acute Rehabilitation unit (IRF) IDT in the completion of required documentation, including assessments and outcomes reflecting each patient's need for intensive rehabilitation and to promote continuity and quality care for Laguna Honda acute rehabilitation patients.
2. To maintain accurate and timely documentation.

### **BACKGROUND**

1. At Laguna Honda Hospital and Rehabilitation Center, the Pavilion Mezzanine Acute Rehabilitation unit is the Inpatient Rehabilitation Facility (IRF). An IRF is a hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients who:
  - a. Can reasonably be expected to actively participate,
  - b. Will significantly benefit from an inpatient stay and the intensity is such that the patient's condition requires this level of care,
  - c. Has complex medical problems that requires the services of a physician, and

- d. Can benefit from an interdisciplinary team approach in the delivery of rehabilitation care.
2. The IRF-PAI is a comprehensive tool to collect standardized patient assessment data to conform to the Centers for Medicare and Medicaid Services (CMS) Regulations which identifies and develops an individualized plan of care for Medicare A eligible patients admitted to the Pavilion Mezzanine Acute Rehabilitation unit (IRF).

## PROCEDURE

### 1. Preadmission Screening (PAS)

The PAS is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment. A PAS (Acute Rehabilitation Pre-Admission Screen MA182) is required for all patients admitted to the Pavilion Mezzanine Acute Rehabilitation unit (IRF). The PAS must:

- a. Be performed by physiatrist or designee who is appropriately trained to assess the patient both medically and functionally.
- b. Be performed within 48 hours immediately preceding the acute rehabilitation (IRF) admission.
- c. Be reassessed if the PAS is completed more than 48 hours prior to the admission. Any changes from the previous assessment must be documented.
- d. Be performed in person or by telephone if records are transmitted for review.
- e. Receive Physiatrist co-sign that the patient meets the requirements for acute rehabilitation (IRF) admission if the PAS was performed by a non-Physiatrist clinician.
- f. Include documentation of the following:
  - i. Specific reasons that the acute rehabilitation (IRF) admission is reasonable and necessary.
  - ii. Patient's prior level of function.
  - iii. Expected length of time necessary to achieve the expected level of improvement.
  - iv. An evaluation of the patient's risk for clinical complications.
  - v. Rehabilitation treatments needed (Occupational Therapy (OT), Physical

- Therapy (PT), Speech Language Pathology (SLP) and/or Orthotics/Prosthetics (O&P)).
- vi. Expected frequency and duration of treatment in the acute rehabilitation unit (IRF).
  - vii. Anticipated discharge destination.
  - viii. Anticipated post-discharge treatments.
  - ix. Other information relevant to the care needs of the patient.
- g. The PAS must be retained in the patient's acute rehabilitation (IRF) medical record.
2. Post-Admission Physician Evaluation (PAPE)
- a. A physiatrist will perform and complete the PAPE (Acute Rehabilitation Pre-Admission Screen MA182) within 24 hours after admission and perform and document an admission evaluation. These documents must support the medical necessity of admission, identify any relevant changes that may have occurred since the PAS, include a documented History and Physical exam, and include a review of prior and current medical and functional conditions and comorbidities.
  - b. The PAPE will capture the patient's status on admission to the acute rehabilitation unit (IRF) compared to that of the PAS, and begin development of the patient's expected course of treatment that will include members of the interdisciplinary team.
  - c. The PAPE may not serve as one of the 3 required physiatrist face-to-face visits in the first week after admission.
  - d. The PAPE must be retained in the patient's acute rehabilitation (IRF) medical record.
  - e. If the PAPE does not support the continued appropriateness of the acute rehabilitation (IRF) services for the patient, the IDT shall begin the discharge process immediately.
3. Overall Plan of Care (POC)
- a. A physiatrist must develop an overall POC within 4 days of admission.
  - b. An overall POC is individualized to the unique care needs of the patient based on information found in the PAS, the PAPE and what is collected in therapy assessments. The overall POC must support the medical necessity of admission



and detail the patient's medical prognosis and anticipated interventions, functional outcomes, and discharge destination from the acute rehabilitation (IRF) stay.

- c. The admission evaluation may serve as documentation of this plan as long as:
  - i. The plan is completed within the first 4 days of the acute rehabilitation (IRF) admission
  - ii. Documentation:
    - Supports medical necessity of admission.
    - Includes details regarding the patient's medical prognosis and anticipated interventions (PT, OT, SLP, O&P) required during the acute rehabilitation (IRF) stay, including details regarding:
      - Expected intensity (numbers of hours/day);
      - Expected frequency (numbers of hours/week); and
      - Expected duration (number of totally days during the acute rehabilitation (IRF) stay).
    - Includes expected functional outcomes.
    - Includes the anticipation destination following the acute rehabilitation (IRF) stay.
- d. The POC must be retained in the acute rehabilitation (IRF) patient's medical record.

#### 4. Physician Orders

- a. The physician must generate orders to admit the patient to the Pavilion Mezzanine Acute Rehabilitation unit (IRF).
- b. A valid physician signature on the physician orders must meet the following criteria:
  - i. Services that are provided or ordered must be authenticated by the ordering practitioner;
  - ii. Signatures are handwritten, electronic, or stamped (in the event of an inability to sign due to a disability); and
  - iii. Signatures are legible.

- c. The orders must be retained in the patient's medical record.

## 5. Multiple Therapy Disciplines

- a. Multiple disciplines (i.e., OT, PT, SLP or O&P) must be actively involved in treating the patient as ordered by the physiatrist.

## 6. Intensive Level of Rehabilitation Services

- a. The minimum intensity requirement for therapy services is 3 hours a day at least 5 days a week or 15 hours of therapy in the 7 consecutive day period, unless the documentation supports medical issues justifying a brief exception not to exceed 3 consecutive days.
- b. Non-medical "missed" therapy minutes in one day need to be made up on another day within the same 7 consecutive day period starting with the day of admission.
- c. Therapy treatments must be initiated within 36 hours from midnight the day of admission.
- d. The acute rehabilitation (IRF) record must demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.
- e. Documentation must clearly indicate the clinician's name, professional credentials and the amount (in minutes) of each therapy service provided for each date.

## 7. Intensive Therapy Program

- a. Documentation must consistently support that the patient's condition necessitates the intense interdisciplinary team approach, including close medical management, close physician supervision, and complexity for nursing services that are all necessary for an acute rehabilitation (IRF) stay. The patient's condition and functional status must be such that he/she can reasonably be expected to make measurable improvement participating in the intensive therapy program available at the acute rehabilitation unit (IRF).
- b. The standard of care for acute rehabilitation (IRF) patients is individualized therapy (not group therapy).

## 8. Physician Supervision

- a. The physiatrist must conduct face-to-face visits with the patient at least 3 days per week throughout the acute rehabilitation (IRF) patient's stay to assess the

patient body medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

- b. The patient's condition and/or status must require the level of physician supervision for the patient's receiving acute rehabilitation (IRF) services.

## 9. Interdisciplinary Team (IDT) Approach

- a. Evidence of an interdisciplinary, coordinated team review should be documented at least once weekly, beginning with the date of admission, to provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care. As such, documentation should include all of the following:
  - i. Evidence of active participation in an interdisciplinary rehabilitation program.
  - ii. Evidence of progress towards stated goals documented by objective functional measures.
  - iii. Identification of the range and severity of the patient's problems, including medical status, self-care, mobility, psychological status and communication status.
  - iv. Consideration of special equipment needs when appropriate.
  - v. Projected length of stay and discharge or disposition planning.
  - vi. Status of training provided to the patient and family member or caregivers by various disciplines of the IDT regarding post discharge care.
  - vii. Identification of barriers to progress, including any medical complications likely to impede progress.
  - viii. Information regarding the status of the underlying medical condition(s).
- b. The documentation of each conference must demonstrate that qualified required participants attended.
- c. The following IDT members must attend interdisciplinary team conferences:
  - i. Psychiatrist;
  - ii. Registered nurse;
  - iii. Social worker or case manager; and

- iv. A licensed or certified therapist from each therapy discipline involved in treating the patient.

10. Discharge from the Pavilion Mezzanine Acute Rehabilitation unit (IRF) is appropriate if one or more of the following is present:

- a. Treatment goals necessitating the inpatient setting were achieved.
- b. Absence of participation in an interdisciplinary rehabilitation program.
- c. The patient's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame.
- d. The patient is unable to actively participate in the intensive rehabilitation program (as defined under Background and Procedure 6. Intensive Level of Rehabilitation Services).
- e. The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected may be achieved at a lower level of care or through regular daily activities.

#### 11. IRF-PAI

- a. An IRF-PAI must be completed and submitted online for all Medicare patients separately at admission and discharge, but will be transmitted to the Centers for Medicare & Medicaid Services (CMS) together only after discharge.
  - i. Within 24 hours after admission of a patient, UM will notify the IDT and Patient Billing if the patient is Medicare A eligible. In addition, UM will inform the IDT of the assessment reference day (ARD). The ARD is defined as the 3<sup>rd</sup> calendar day of the rehabilitation stay, which represents the last day of the 2-day admission assessment time period. If the stay is less than 3 calendar days, the admission ARD is the last day of the stay. If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days.
- b. The information in the IRF-PAI must correspond with the information provided in the patient's IRF medical record and must support the appropriate claim coding.
- c. Members of the IDT are responsible for completing their assessments and documentation forms that will be used to fill out their respective IRF-PAI sections by the ARD. Each discipline is responsible for completing documentation as outlined in Appendix C.
- d. At admission and discharge, a designated acute rehabilitation (IRF) registered

nurse (RN) will review the medical record and Medicare A assessments of the IDT, and complete the IRF-PAI using the electronic validation and entry system by Day 4. The nurse will print the completed IRF-PAI, complete the signature page and retain the document in the patient's medical record.

- e. After the patient is discharged and the discharge IRF-PAI has been completed, the nurse will notify the Resident Assessment Instrument (RAI) Department nurse that the IRF-PAI is completed and ready for transmission.
- f. After the patient is discharged, the Admission and Discharge IRF-PAI will be transmitted to CMS by LHH's RAI Department nurse within 24 hours after the notification of IRF-PAI completion.
  - i. Admission and discharge IRF-PAI items must be completed before data records are transmitted to CMS. If the patient's stay is less than 3 calendar days in length, the staff of the IRF must complete the IRF-PAI admission items, but do not have to complete all of the discharge IRF-PAI items. However, for the discharge assessment, an IRF registered nurse must complete all of the functional modifiers and FIM® (Functional Independence Measure) instrument items.
    - The FIM is a basic indicator of severity of disability. The data generated can be used to track changes and analyze the outcomes of rehabilitation. The seven-level scale rates patients on their performance of an activity taking into account their need for assistance from another person or device.
  - ii. Program interruption: the situation where a Medicare patient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days.
  - iii. Discharge Date: the date the patient is discharged from the IRF and stops receiving Medicare-covered Part A fee-for-service inpatient rehabilitation services.
- g. Any staff member that has gathered information from a patient's medical record to complete any section of the IRF-PAI is responsible for signing the signature page. The signature page does not need to be completed by every person that contributes to the patient's medical record, only the staff that are completing the IRF-PAI are required to sign the signature page.

## 12. Provision of Medicare Rights Form

- a. A financial counselor will meet with Medicare recipients upon admission to review the Medicare Rights form and secure a signature from the patient or responsible party.

b. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient is discharged before a copy can be given, a copy will be mailed to the patient by the Eligibility department.

c. Refer to LHHPP 55-01 Payor Eligibility Certification and Coverage

<b>ASSESSMENT TYPE</b>	<b>ADMISSION ASSESSMENT</b>
Hospitalization Time Period and Observation Time Period	First 3 Calendar Days (Admission day = Day 1)
Assessment Reference Date	Day 3
Patient Assessment Instrument Must Be Completed By	Day 4
Payment Time Covered By This Assessment	Entire Medicare Stay Time Period
Patient Assessment Data Must be Encoded By	Day 10
Patient Assessment Instrument Data Must Be Transmitted By	Same day as discharge data are transmitted: 7 <sup>th</sup> calendar day from the encoded by date

<b>ASSESSMENT TYPE</b>	<b>DISCHARGE ASSESSMENT</b>
Discharge Date	Discharge Date (Day 1)
Assessment Reference Date	Discharge Date
Patient Assessment Instrument Must Be Completed On	Day 4 of Discharge
Patient Assessment Instrument Data Must be Encoded By	Day 10 of Discharge
Date When Patient Assessment Instrument Data Transmission is Late	27 calendar days

**ATTACHMENT:**

Attachment A: IRF-PAI Section by Section

**REFERENCE:**

- IRF-PAI Manual 1.3 (effective until September 30, 2016)
- IRF-PAI Manual 1.4 (effective starting October 1, 2016)
- Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
- Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

**CROSSREFERENCE:**

LHHPP 55-01 Payor Eligibility Certification and Coverage

**Attachment A: IRF-PAI Section by Section**

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT	
Section	Responsible Discipline(s) – Financial Counselor
1-19: Identification Information	Admission & Eligibility – Financial Counselor
20: Payer Information	Admission & Eligibility – Financial Counselor
21-28: Medical Information	Admission & Eligibility – Financial Counselor
29-38: Function Modifiers	Rehabilitation – OT, PT, SLP, others
39: FIM Instrument (excluding the Sphincter Control section)	Rehabilitation – OT, PT, SLP, others
39: FIM Instrument (Sphincter Control section)	Nursing - RN
40-47: Discharge Information	Nursing (RN) & Social Services (SW)
O0401-O0402: Therapy Information	Rehabilitation – OT, PT, SLP, other
Z0400A: Signature of Persons Completing the Assessment	Nursing - RN
INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS (ADMISSION) *beginning October 2016	
Section	Responsible Disciplines(s)
B: Hearing, Speech, and Vision	Nursing - RN
C: Cognitive Patterns	Nursing - RN
GG: Functional Abilities and Goals	Rehabilitation – OT, PT, SLP, others
H: Bladder and Bowel	Nursing - RN
I: Active Diagnoses	Health Information Services (HIS coder) & Medicine (Physiatrist)
J: Health Conditions	Nursing (RN) & Medicine (Physiatrist)
K: Swallowing/Nutritional Status	Nursing (RN), Medicine (Physiatrist) & Dietary (RD)
M: Skin Conditions	Nursing - RN
O: Special Treatments, Procedures, and Programs	Medicine - Physiatrist
INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS (DISCHARGE) *beginning October 2016	
GG: Functional Abilities and Goals	Rehabilitation – OT, PT, SLP, others
J: Health Conditions	Nursing - RN
M: Skin Conditions	Nursing - RN
O: Special Treatments, Procedures, and Programs	Nursing - RN

## PROCUREMENT CARD

### POLICY:

Laguna Honda Hospital (LHH) utilizes a procurement card (P-Card) for the acquisition of materials, supplies, and services that are not readily available through the normal purchasing mechanism due to the unique needs of resident programming, physician credentialing, and disaster response.

### PURPOSE:

To ensure a process for the procurement of materials, supplies, and services that is efficient and maintains appropriate internal controls in compliance with City Controller's policy.

### CHARACTERISTICS:

1. P-Cards are used to procure non-medical resident related materials, supplies and services within the Activity Therapy, Rehabilitation, Social Services, and Substance Treatment and Recovery Services (STARS) programs. The LHH Gift Fund is the funding source for these programs.
2. Use of P-Cards for physician credentialing and disaster response is appropriate only when normal purchasing mechanisms are prohibitive.

### PROCEDURE:

1. The Chief Financial Officer (CFO) or designee maintains the role of **Department Coordinator** for the P-Card program. Responsibilities include:
  - a. Oversight of the P-Card program for the hospital.
  - b. Approves requests for P-Cards from Approving Officials.
  - c. Reviews and approves reports for P-Card use and performance.
  - d. Liaison with the P-Card Coordinator in the Controller's Office.
2. The Director of Wellness and Therapeutic Activities, Manager of Rehabilitation Programs, Director of Social Services, Director of Psychology, and the Chief Medical Officer or designees maintain the role of **Approving Officials** for the P-Card program within their respective departments. Responsibilities include:
  - a. Oversight of proper P-Card use within their departments.



- b. Make requests to Department Coordinator for P-Cards for employees under their supervision. Notify Department Coordinator of change of employment status of cardholders within their departments.
  - c. Approve cardholder purchases, and verify that purchases are made for official hospital business.
  - d. Review and certify the reconciled Cardholder Statements of Account, and ensure that original receipts and documents are in order.
  - e. Ensure that each cardholder statement of account is accounted for and forward them to the Billing Official.
3. The Gift Fund Program Manager maintains the role of **Billing Official**. Responsibilities include:
- a. Receives, reviews, and ensures accuracy of account statements, receipts, and reconciliation reports.
  - b. Facilitates monthly P-Card payments to U. S. Bank and charges expenses to proper accounts.
  - c. Determines whether proper sales tax has been paid and accrue any use tax.
  - d. Prepares reports for the Department Coordinator.
4. Assigned staff of the above mentioned programs are **Cardholders**. Responsibilities include:
- a. Review and consent the CCSF P-Card Cardholder Guide.
  - b. Maintain security of the account number and P-Card.
  - c. Make appropriate purchases while securing the value for the hospital.
  - d. Secure itemized original receipt at the point of purchase and verify for accuracy.
  - e. Complete expense form.
  - f. Reconcile all transactions and forward original receipts and expense forms to Approving Official.
  - g. Cardholders shall return P-Card to Department Coordinator if position duties change.
5. All staff involved with P-Card, shall complete training developed by the Controller's Office and comply with the standards established in the City and County of San Francisco's policy on Procurement Card.

6. All P-Cards issued to cardholders will have a default credit limit of \$1,000.
7. The expenses in support of Activity Therapy, Rehabilitation, Social Service, and STARS programs may not exceed Gift Fund budget limits established by the Gift Fund Committee and approved by the Health Commission.
8. Potential cardholders/requesters shall complete a Procurement Card Request Form with approval from their department head and the LHH CFO. The requesters shall indicate and sign the request form acknowledging that they have read and understand the P-Card policy.
9. Cardholders shall make purchases in support of department programs.
10. Cardholders shall download and print monthly statements, reconcile all transactions, and forward all documentation including original receipts and expense forms to their respective Approving Officials prior to the 28<sup>th</sup> of each month. If the 28<sup>th</sup> falls on a weekend, the original receipts are forwarded to the Approving Official on the previous business day.
11. Approving Officials shall review P-Card documentation and approve Cardholder transactions in U.S. Bank Access Online system.
12. Approving Officials shall forward P-Card documentation to the Billing Official by the 2<sup>nd</sup> of the following month unless it falls on the weekend, then the previous business day.
13. The Billing Official shall review P-Card documentation and make monthly payments through Accounting staff to U.S. Bank by the 6<sup>th</sup> of each month or prior if falls on the weekend.
14. The Department Coordinator or designee shall approve all entries in City's Financial System.
15. The Accounting Cashier Supervisor shall reconcile the U.S. Bank statements by the 16<sup>th</sup> of each month.

P-Card statements generated on the <b>25<sup>th</sup></b> of each month or previous business day if the 25th falls on a weekend. Card payment due <b>14 days</b> from the statement date		
Staff/Role	Description	Monthly Due Date
Cardholder	Downloads statement, reconciles transactions and submits original receipts with expense form to Approving Officer	28th or prior if weekend
Approving Officer or Designee	Reviews & approves Cardholder documents and submits them to Billing Officer/Accounting Department	2nd or prior if weekend
Billing Officer/Accounting	Review, process, and approve payment to U.S. Bank in City's Financial System	6th or prior if weekend

P-Card statements generated on the <b>25th</b> of each month or previous business day if the 25th falls on a weekend. Card payment due <b>14 days</b> from the statement date		
<b>Staff/Role</b>	<b>Description</b>	<b>Monthly Due Date</b>
Accounting Cashier Supervisor	Reconciliation of bank statements	16th or prior if weekend

## 16. Declared Emergency and Natural Disasters

- a. Emergency purchases during Declared Emergencies and Natural. Refer to San Francisco Administrative Code Section 21.15 and Section 6.60 for emergency procurement procedures and who can declare emergency. Disaster P-Cards do NOT replace the City's existing Emergency Purchasing Procedures, but will supplement the procedures.
- b. Prior to an emergency being declared, the CFO will request pre-approval of a credit limit increases in the event of an emergency. When an emergency is declared, the department will take the following steps to increase P-Card credit limit should the need of credit limit increase arise:
  - i. The CFO or designee will contact the Citywide P-Card Administrator to request an emergency increase to the P-Card credit limit.
  - ii. The City Controller's Office will contact U.S. Bank to increase the credit limit.
- c. The CFO or designee will coordinate all purchases in response to an emergency or disaster.
- d. The CFO is responsible for reconciling all transactions and forwarding original receipts and expense forms to the Executive Administrator for verification.
- e. All Documentation related to emergency and disaster purchases are forwarded to the Office of the Controller for financial processing.

### **ATTACHMENT:**

Attachment A: Procurement Card Request Form

### **REFERENCE:**

LHHPP 45-01 Gift Fund Management  
 CCSF Procurement Card Policy and Procedures  
 CCSF Purchasing Cardholder Guide  
 San Francisco Administrative Code Section 21.15 and Section 6.60

Original adoption: 16/11/08 (Year/Month/Day)

Attachment A: Procurement Card Request Form

Procurement Card Request Form

Name	<input type="text"/>	DSW #	<input type="text"/>
Department	<input type="text" value="Department of Public Health"/>	Department Code	<input type="text" value="DPH"/>
Division	<input type="text" value="Laguna Honda Hospital"/>	Division Code	<input type="text" value="HLH"/>
Program	<input type="text"/>		
Job Title	<input type="text"/>	Job Class #	<input type="text"/>
Address	<input type="text" value="375 Laguna Honda Boulevard"/>	Room #	<input type="text"/>
City	<input type="text" value="San Francisco"/>	State/Zip Code	<input type="text" value="California, 94116"/>
Work E-mail	<input type="text"/>	Work Phone	<input type="text"/>
Approving Officer of Designee	<input type="text"/>		

I have read and understand the hospital policy and procedure of the use of Procurement Cards

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Department Head

\_\_\_\_\_  
Signature

Chia Yu Ma, Chief Financial Officer

\_\_\_\_\_  
Signature

**Use of the Medi-Therm Hyper/Hypothermia Machine®**

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## **MEDI-THERM II HYPER/HYPOTHERMIA MACHINE®**

### **POLICY:**

1. The Medi-Therm II Hyper/Hypothermia Machine® is provided to a resident based upon a clinical assessment of a resident whose core temperature is above or below his/her normal temperature. It is not indicated solely for comfort.
2. The manual mode of operation, including the prescribed blanket, use of a patient/resident rectal probe to monitor resident's temperature, and duration of use require a physician's order.
3. Resident's temperature, condition of the skin in contact with the blanket, and the blanket water display are checked every 20 minutes, and as clinically indicated, and discontinued once the core temperature is normal.
4. Residents who have impaired skin sensation or are unable to report skin sensory perception, or refuse a rectal probe temperature check, are contraindicated. **ADD CONTRAINDICATIONS**
5. After adjusting the room temperature and exploring other options (i.e., providing additional clothing/blankets, warm liquids, relocation, etc.), use of the Medi-Therm II Hyper/Hypothermia Machine may be needed to help regulate the patient/resident's temperature.
6. Resident and/or responsible parties will be educated on the risks of the Medi-Therm II Hyper/Hypothermia Machine®.

### **PURPOSE:**

To safely provide hyper/hypothermia therapy to a patient/resident.

### **DEFINITIONS:**

The Medi-Therm II Hyper/Hypothermia Machine is a device that may be used to help regulate a patient/resident's temperature via temperature-controlled water that flows through a hyper/hypothermia blanket.

This treatment is generally considered aggressive therapy for pathophysiologic hyper/hypothermic dysregulation.

---

### **PROCEDURE:**

#### **A. Equipment:**

Refer to the user's manual and instructions on the machine for complete details of the following procedures:

- Medi-Therm II Hyper/Hypothermia Machine® Distilled Water
- Hypo/hyperthermia blanket
- Patient/resident Rectal Probe

**B. Start-Up Procedure**

1. Filling the Water Supply
  - a. Raise the water fill opening and fill with distilled water ONLY until the green band on the float is visible. Do NOT use alcohol, operate without water, or overfill machine
  - b. Recheck water level indicator 5 minutes after starting and before attaching a second blanket and refill if needed.
2. Attaching/Replacing Blanket
  - a. Close the pinch clamps on the connector hose and blanket and attach the connector hose to the Medi-Therm II® machine and the blanket. Verify that the attachments are secure by snapping the locking ring into place.
  - b. Open the pinch clamps, check/re-check the water level, and plug machine to a power receptacle. Check that the water blankets are not leaking to prevent electrocution and to decrease the risk for infection.
3. Press the *ON/OFF* switch to *ON* position and perform the indicator light test by pressing and holding the *TEST LIGHTS* button and verifying that all lights function properly and alarm sounds. Do NOT use if lights or alarms are not functioning.
4. Place the patient/resident probe if ordered and wait five minutes before choosing the Mode of Operation.
5. Discontinue treatment IMMEDIATELY when resident is normothermic, there is evidence of skin impairment, or hypo/hypertensive and notify the physician.

**C. Resident/Patient Rectal Probe**

1. Insert and secure the sensing end of the rectal probe into the patient/resident.
2. Insert the plug end of the patient/resident probe into the PATIENT PROBE jack.
3. The patient/resident's temperature will show on the PATIENT temperature display.
4. If the patient/resident probe senses an abnormal patient/resident temperature (below 32°C/89.6°F or above 45°C/113°F), therapy will stop and CHECK PATIENT Probe alert will light and sound. Verify the placement of the probe, perform PROBE CHECK (see manual), and replace probe or machine if needed.

**D. Manual Mode (machine heats/cools blanket water temperature to the selected SET POINT temperature)**

1. Press the MANUAL mode button.
2. The BLANKET display will show the current blanket temperature
3. The SET POINT display will initially show the default temperature of 32°C/89.6°F. Change the temperature scale to Celsius or Fahrenheit by pressing the C°/F° button
4. Refer to the physician's orders and adjust the SET POINT display to the prescribed blanket temperature by pressing the up or down arrows.

**Use of the Medi-Therm Hyper/Hypothermia Machine®**

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5. The STATUS display will show HEAT or COOL as the machine heats or cools the blanket water. When the blanket temperature stabilizes to the SET POINT temperature, the IN-TEMP indicator will light indicating the desired blanket water temperature is being maintained.
6. Do NOT place additional heat sources between the resident and the blanket. Keep the resident's skin dry.

**E. Documentation**

1. On the Treatment Administration Record, the licensed nurse will monitor:
  - i. Start and End of treatment
  - ii. Vital signs at start of treatment
  - iii. Vital signs every 20 minutes x 1 hour, then hourly
  - iv. Rectal temperature and skin checks every 20 minutes
  - v. Blanket SET POINT temperature
2. Integrated Progress Notes (done every shift while on therapy)
  - i. Resident response to treatment
  - ii. Adverse effects

**REFERENCES:**

Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 4<sup>th</sup> edition, 2007

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

Reviewed: 8/2002, 3/2010, 10/2010; 03/25/2014

Revised: 03/25/2014

Approved: 03/25/2014

# T/PUMP®

TP702 Localized Temperature  
Therapy System



Operator's Manual [EN]

**CE**  
**0086**



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BEFORE YOU BEGIN . . .

Read and understand this T/PUMP OPERATOR'S MANUAL and all SAFETY PRECAUTIONS (see page 3) prior to using the T/Pump.











Only qualified medical service personnel should repair or perform function tests on the T/Pump. Contact your dealer or Gaymar's Technical Service Department for assistance:

Telephone: 716 662-2551

RECEIVING INSPECTION

Check the shipping carton for damage immediately upon receipt. If package damage is discovered, the device should be unpacked with the carrier's agent present. Any claims for shortage or damage must be filed with the delivering carrier by the purchaser. Do not return pumps that were damaged in shipment to GAYMAR without contacting our Technical Service Department for advice (see phone numbers below). If damaged goods are returned to GAYMAR without notifying the carrier, GAYMAR will assume the repairs will be made at the customer's expense.

SYMBOLS USED WITHIN THIS MANUAL AND ON THE PRODUCT

	Warm Water Fill Line
	Cold Water Fill Line
	Attention, consult Operator's Manual.
	Water Levels
	Water Flow
	Dangerous Voltage
	Type BF Applied Part
	Do not penetrate with sharp object.
	Length of cycle time
	Continuous

TO RETURN PUMPS TO FACTORY FOR REPAIR OR EXCHANGE

Merchandise returned to GAYMAR must be accompanied by a Return Goods Number (RG#), issued by GAYMAR, authorizing goods to be returned. Contact your local dealer or Gaymar's International Department at:

International: +1 716-662-8636  
Fax: +1 716-662-0730

Provide the model, serial number, and detailed nature of the problem. You will be given a Return Goods Number (RG#).

The serial number can be found on the bottom of the T/Pump.

T/PUMP, T/PAD, Mul•T•Pad, Klik-Tite, and Gaymar are registered trademarks of Gaymar Industries, Inc. U. S. PATENT 4,068,870

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SAFETY  
PRECAUTIONS

 DANGER

- Risk of explosion. Do not use in the presence of flammable anesthetics.
- Risk of electric shock. Disconnect power before servicing the

 WARNING

- This device pumps temperature controlled water through a pad. Set the pad temperature only as directed by and under the guidance of the prescriber.
- Check the skin integrity of the body surface to which therapy is applied. Evaluate patient response to temperature application.
- Check patient's skin for adverse reactions every 30 minutes or as directed by the prescriber.
- Failure to adhere to these warnings could result in patient injury.
- The following Groups/Conditions require additional surveillance:

Group/Condition at risk	Potential Injury
Pediatric patients: The portion of an infant's skin surface in contact with a pad, in relationship to their body mass, can potentially affect their body temperature.	Hyperthermia/ Hypothermia
Patients with impaired circulation	Ischemia
Areas of application under pressure	Ischemia

- Only qualified medical service personnel should repair the T/Pump. Improper repair may result in death or serious injury, equipment damage, or malfunction.
- Use T/Pump TP702 controls with Mul•T•Pads. For catalog numbers and descriptions, see page 5.
- Do not place additional heat sources between the patient and pad. Skin damage may result.

 CAUTION

- Federal law restricts this device to sale by or on the order of a physician.
- Do not cover the control unit with blankets, pillows or other insulating materials. Air flow is required to maintain system performance.

INTRODUCTION

Heat therapy is effective in the dilation of blood vessels, thereby increasing the blood flow to the heated area. Heat therapy has a variety of uses, the most common being treatment of aches and pains in joints and muscles.

Cooling therapy assists in vasoconstriction, decreasing blood flow and decreasing the metabolism in the affected area. Cooling therapy is applied in the acute phase of injury minimizing blood loss, inflammation of the tissue, and can be effective in pain management.

The GAYMART/Pump® Localized Temperature Therapy System provides therapy by warming or cooling the enclosed water, and circulating it through the Gaymar Mul•T•Pad. The pad is connected to the Gaymar T/Pump with easy-to-use Clik-Tite® connectors.

The Mul•T•Pad provides the interface for delivering the temperature therapy. The unique button design allows water to flow and provides trouble-free operation when the pad is folded to form a customized fit. This reduces the number of pads your facility must keep in inventory. The pads are applied to the part of the body requiring therapy, and the circulating water maintains the pad at the setpoint temperature. The setpoint temperature can be locked to prevent tampering.

Connecting the Pads

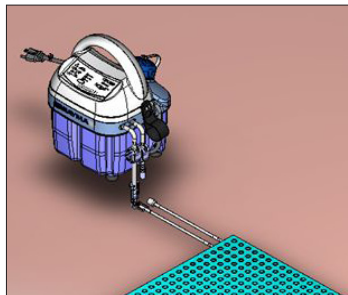


Figure 1A: Localized Temperature Therapy System with Single Pad with the TP702.

The Mul•T•Pads can be interconnected using Clik-Tite® connectors to provide therapy to more than one body site at a time.

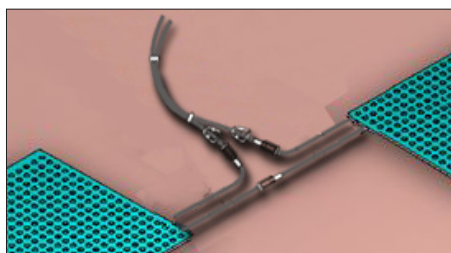


Figure 1B: Localized Temperature Therapy System with Multiple Pads.

Catalog Descriptions

Catalog #	Product Name
TP702	Professional Control Unit
TP22B	Mul•T•Pad: 15" w x 22" l (38cm x 56cm) All Polymer. 10 per carton
TP22C	Mul•T•Pad: 15" w x 22" l (38cm x 56cm) Nonwoven fabric on one side, pliable polymer on the other side. 1 per carton
TP3E	Mul•T•Pad: 3" w x 23" l (8cm x 58cm) Nonwoven fabric on one side, pliable polymer on the other side. 10 per carton
TP12E	Mul•T•Pad: 13" w x 18" l (33cm x 46cm) Nonwoven fabric on one side, pliable polymer on the other side. 20 per carton
TP22E	Mul•T•Pad: 15" w x 22" l (38cm x 56cm) Nonwoven fabric on one side, pliable polymer on the other side. 20 per carton
TP26E	Mul•T•Pad: 18" w x 26" l (46cm x 66cm) Nonwoven fabric on one side, pliable polymer on the other side. 10 per carton
TP22G	Mul•T•Pad: 15" w x 22" l (38cm x 56cm) Heavy Polymer, Reuseable. 10 per carton

To order any of these products contact your dealer or Gaymar's International Department at:

International: +1 716-662-8636

Fax: +1 716-662-0730

Or, visit our website at [www.gaymar.com](http://www.gaymar.com)

INDICATIONS FOR USE

Localized temperature therapy is recommended in treating the following applications:

Orthopedic Conditions such as:

acute injuries, chronic pain, lower back pain, muscle spasm and strains

Skin Trauma such as:

abscesses, boils, bruises, burns and contusions

Cold Indications

muscle spasm  
contusions  
tendonitis  
pain management

Other conditions such as:

chronic arthritis, neuritis, phlebitis, tendonitis and I.V. infiltration, infection and localized pain.

Other applications only as prescribed.

OK for Use With:

- Non-acute traumatized tissue.
- Impaired mental status.
- Insensate body surface.
- O<sub>2</sub> therapy. However, if oxygen tent is in use, do not use pump inside tent.

CLINICAL  
CONTRAINDICATIONS

Heating contraindications are:

- Application to a body surface with compromised blood flow (Ischemia, area under pressure, arterial insufficiency).
- Application to a patient with an increased tendency to bleeding (aggravates potential for hemorrhage).
- Application to a body surface with possibility of malignancy (tissue metabolism is increased and therefore, the growth potential of the malignant tissues).
- Treatment of hematoma within first 24-48 hours (potential for re-bleeding and hemorrhage).
- Recent sprain or fracture (acute inflammatory response).
- In combination with topical solutions whose toxicity may be affected by the application of heat.
- In combination with other heat sources.

Cooling contraindications are:

- Application to a body surface with compromised blood flow or hypersensitivity to cold. (Ischemia, Reynauds Syndrome).

PUMP FEATURES

Easy to Use Keypad	See KEYPAD FEATURES on page 8.
Attached hose	10 ft (305 cm) dual hose. Connectors allow pads to be connected to the pump (Figures 1A and 1B, page 4).
Flow indicator	Indicates no flow. Turns off heater if pump is tipped.
Warm/Cool Delivery	Four temperature setpoints on the TP702.
Therapy Cycles	Choose from 20-minute, 30-minute, or Continuous cycles.
On/Standby Button	Indicates power is supplied to the unit.
Over Temp Safety Thermostat	Limit thermostat shuts off pump and heater if the high temperature limit is exceeded.
Self Check	Automatic system check at startup.
Hose/cord Management	Convenient and easy storage areas for hose and cord.
Comfortable Handle Design	Designed for a more comfortable grip when moving the pump.
Dual Micro Processor	Two electronic circuits, one over temperature sensing circuit.
Tethered Easy-Open Cap	Prevents misplacing the cap. Only 1/4 of a turn is needed to remove or secure the cap.
Handle Vents	The vents in the handle allow air flow to keep the motor and heater inside the unit cool.

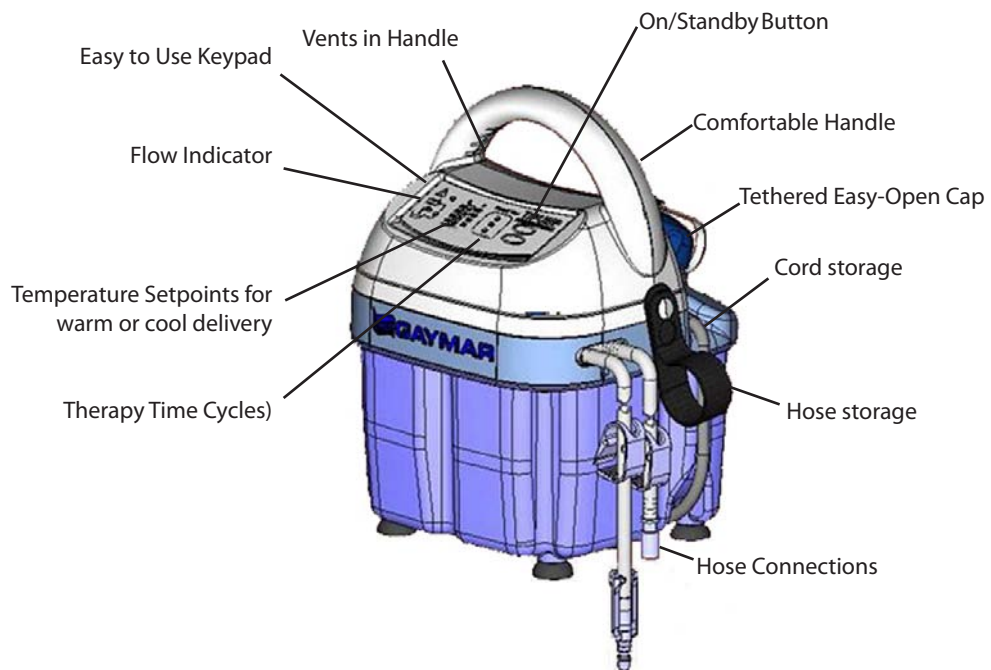


Figure 2: T/Pump Features

KEYPAD FEATURES  
TP702

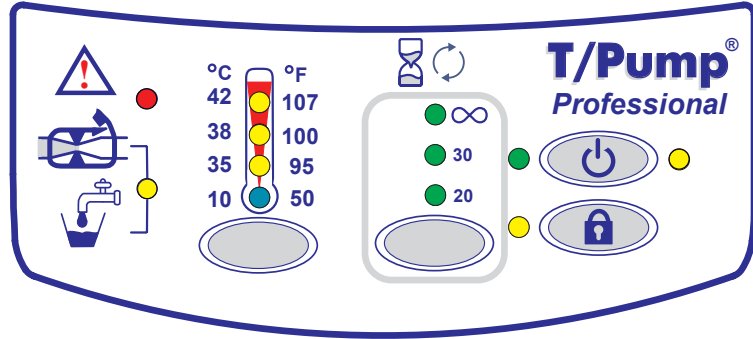



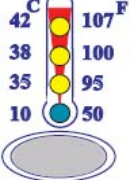


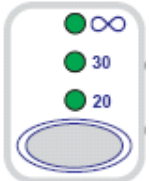


Figure 3: TP702 Keypad

Indicator/ Warning Light	 <p>See the Troubleshooting section on page 12.</p>
	 <p>Water Flow Check hoses or clamps for kinks or occlusions.</p>
	 <p>Water Level Check water level.</p>
Setpoints	<p>Press the button at the bottom of the setpoint indicator to toggle through the four setpoints. Temperatures are identified in °C and °F.</p> 
Setpoint Lock	<p>Prevents tampering. Press and hold for 2 seconds to lock or unlock the setpoint.</p> 
Therapy Cycles	  <p>Continuous cycle, 30-minute cycle 20-minute cycle.</p>
	<p>Green indicates the unit is on. Yellow indicates power is supplied to the unit but the unit is not on.</p>

CLIK-TITE® CONNECTORS

Note: Refer to Figure 1B on page 4 when connecting multiple pads.

The TP702 T/Pump is supplied with Clik-Tite® connectors.

To connect and disconnect Clik-Tite® connectors from hose to pad:

1. Insert male fittings into female fittings with a twisting motion (Figures 4A and 4B).
2. When fittings are fully inserted, snap locking ring into place (Figures 4C and 4D).
3. To disconnect, reverse the procedure.
4. To open or close the hose pinch clamps:
  - Open the clamp by pushing the serrated end (Figure 5B).
  - Close the clamp by pressing the clamp together (Figure 5C).

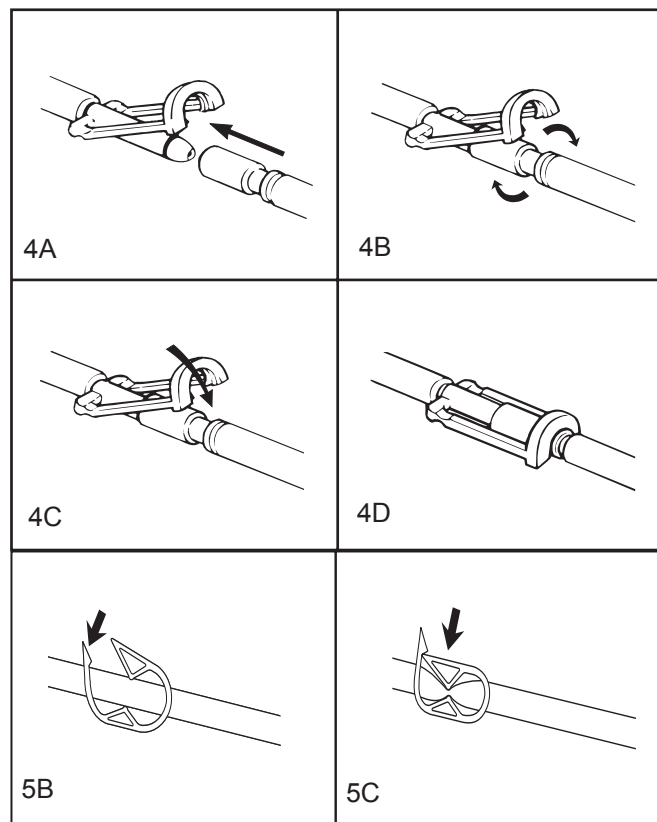




Figure 4: Clik-Tite® Connectors



START-UP PROCEDURE

1. Before filling the pump, always attach a pad to the connector hose or close the clamps on the connector hose ends. Make sure that there are no kinks in the hose or pad. Open the hose clamps.
2. Open the fill cap on top of the pump.
3. To fill for cooling:
  - a. Fill with cold water to the Cooling water line.
  - b. Fill with ice to the full capacity of the reservoir. 
4. To fill for heating, fill with room temperature water to the Heating water line. 
5. Plug the T/Pump into a properly grounded Hospital Grade receptacle.
6. Press the On/Standby button.  
The light next to the selected temperature begins to flash.
7. Use the keypad to set the temperature as directed by the prescriber. After setting the temperature, press and hold the lock Temperature Setpoint button for 2 seconds to lock the setpoint.  
  
Note: If you toggle past the desired setpoint, keep toggling to start at the beginning of the setpoint column.  
  
If warming, the selected water temperature will be reached in approximately 11 minutes and the light next to the selected temperature becomes steady.
8. Check the water level. If it drops below the operating level, add water.
9. Apply the Mul•T•Pad to the patient as prescribed. Follow the Mul•T•Pad instructions.
10. Position the pump at or above the level of the pad.  
  
Note: If the pump is placed below the pad(s), water will drain into the pump when it is shut off. If the pump has been overfilled or if multiple pads are connected, excess water can leak.

SHUTDOWN PROCEDURE

1. Press the On/Standby button so that the Standby light is lit.
2. Unplug the T/Pump.
3. Close all hose clamps.
4. Disconnect pad(s) from pump.  
To prevent water spillage, always disconnect pad from pump with connectors raised above the level of the pad and pump.
5. Coil the hose, and attach the Clik-Tite® connectors together on the hose (See Figure 4, Page 9), where applicable.
6. Secure the hose to the T/Pump using the tube set strap.
7. Wrap the power cord around the unit.

THERAPY CYCLES,  
PROFESSIONAL ONLY

Therapy Cycles:

1. Turn the unit on, and place it into 20 (or 30) minute therapy cycle. The unit will start to heat up. Select warming period for 20 (or 30) minute cycle, LED should be solid, and the selected temperature LED is flashing.
2. Once the T/Pump reaches the desired temperature, the Warming LED (Red) flashes with a short audible beep. This is to let the operator/user know the unit is at temperature and the timed therapy is starting. The warm-up period will take about 5 to 10 minutes depending on the selected Setpoint.
  - a. Note: If this is not the first time the unit has cycled (the unit is already warmed up) the warm up period is about 2 minutes.
3. Once the 20 (or 30) minute period is up, the heater and pump shuts off. This stops any flow to the pad. The Setpoint and Therapy time LED's will be blinking during the off Time period. This is to inform the operator that the unit is not just in standby. During this time the pad temperature will slowly drop to the patients body temperature.
4. Once the Off Time period is up, the pump and heater will restart. The patient may feel a cooling in the pad due to the drop in temperature in the hoses. Time Therapy LED goes solid, and the Setpoint LED will flash until the system temperature reaches the Setpoint. Once the Setpoint is reached the Red LED flashes with a short audible beep to let the operator/user know the next therapy cycle has started.

TROUBLESHOOTING

Problem	Possible Cause	Remedy
T/Pump will not turn on.	The electrical cord is not plugged into a properly grounded Hospital Grade receptacle.	Insert the plug fully into the properly grounded Hospital Grade receptacle.
T/Pump will not pump.	Water level is low or reservoir is empty.	Refill with room temperature water to proper level.
Flow indicator light is on.	<p>Water flow to pad or hose is restricted.</p> <p>Clamp is closed.</p> <p>Water level is low or reservoir is empty.</p> <p>T/Pump is filled with water that is too hot.</p>	<p>Straighten the hose.</p> <p>Open the clamp.</p> <p>Refill with room temperature water to proper level.</p> <p>Refill with room temperature water to proper level.</p>
Warning indicator & Audible alarm (Flash / Beep).	<p>A High Heat (107°F / 42°C) or Cooling Setpoint was selected (50°F / 10°C).</p> <p>Loss of power while unit was in a Therapy mode. (Possible Power Fail.)</p> <p>Unit is running after a 20- or 30-minute "Off" therapy cycle period, has reached the desired Setpoint, and is now timing the 20- or 30- minute On cycle period.</p> <p>The unit just went into, or came out of Lock mode.</p> <p>Safety Circuit Function Test has started. Note: This would be followed with the unit starting, while still in Standby mode. See the Functional Check section on page 18 for details.</p>	<p>Indication only: A Setpoint outside body temperature range is selected.</p> <p>Insert the plug fully into the receptacle, place the unit into Standby mode, then unplug the T/Pump. If power is removed while unit is in On-Mode, the Power Fail alarm will beep for approximately 10 minutes.</p> <p>Indication only to indicate an "On" Therapy cycle period is timing.</p> <p>Indication only.</p> <p>Note: This should only be performed by medical service personnel. If this mode was started in error, press the On/Standby button to stop the test and go back to Standby mode with the pump off.</p>

Problem	Possible Cause	Remedy
T/Pump running with the Standby light on.	Safety Circuit Function Test has started. Note: This would be followed with the unit starting, while still in Standby mode. See the Functional Check section on page 18 for details.	Important: This should only be performed by medical service personnel. If this mode was started in error, press the On/Standby button to stop the test and go back to Standby mode with the pump off.
Warning indicator on with unit in Standby mode.	Unit shut down in an over temperature condition.  Safety Circuit Function Test completed successfully.	Empty the reservoir and refill with room temperature water. Make sure all clamps are open. Press the On/Standby button. Verify flow through the pad. The Warning light will turn off within 5 minutes.  Allow the system to cool for 60 minutes or until the Warning light turns off.
Flow indicator and Standby indicator are on with T/Pump not pumping.	Unit detected a Flow warning for more than 5 minutes, thus goes to standby.	Reference "Flow indicator light is on" above. Correct the problem, and press the On/Standby to put the unit back into Run mode.
Temperature Setpoint light blinking.	Unit is warming up to the selected setpoint.  Unit is in Cooling mode, for longer than 40 minutes.	Indication only.  Follow the shutdown procedure. Drain the water in reservoir to ice fill level, and refill with ice. Follow the start-up procedure.

Problem	Possible Cause	Remedy
Both the Temperature and Therapy Cycle Setpoint lights are blinking.	Unit is in "Off" Therapy cycle time.	Indication only.
T/Pump will not heat.	Reservoir is empty.  Flow is blocked.	Refill with room temperature water to proper level.  Reference "Flow indicator light is on" above.
T/Pump will not cool.	Reservoir is empty.  Flow is blocked.  Ice is depleted.	Refill with room temperature water to proper level.  Reference "Flow indicator light is on" above.  Drain excess water to Cooling water line and fill remainder of reservoir with ice.
Temperature or Therapy Time buttons do not work.	The buttons have been locked.	Press and hold the lock button for two seconds.
Water leaks from hose connectors.	Damaged O-ring.  Locking ring on Klik-Tite® connector is not snapped into place (See Figure 4 on page 9.)	Replace Klik-Tite® connector.  Snap Klik-Tite® connector shut.

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STORAGE / CLEANING

Storage (Short term)  
Less than 1 day

1. Close the hose clamps.
2. Disconnect the pad.
3. Connect ends of the connector hoses together, where applicable.
4. Open the hose clamps.
5. Leave water in the reservoir.
6. Coil and fasten the hose using the tube set strap and wrap the power cord around the unit.

Storage (Long term)

1. Drain the pump. (See instructions below.)
2. Coil the hose, rather than folding it, to prevent hose kinks.
3. Fasten the hose using the tube set strap and wrap the power cord around the unit.

Draining

1. Disconnect the T/Pump from AC power.
2. Clamp the hose clamps.
3. Disconnect the pad or hoses from one another, keeping hoses at or above the level of the T/Pump.
4. Open the hose clamps.
5. Remove the fill cap and invert the T/Pump over a sink.
6. When all fluid has drained from the hoses and reservoir, replace the fill cap.
7. Connect the hoses together, where applicable.

Institutional  
(Hospital) Cleaning  
Instructions

Note: Clean and change the water monthly or more often depending on use.

Clean the outer surfaces of the T/Pump with one of the following:

- A damp cloth and soapy water.
  - A spray cleaner such as Fantastik
  - A mild abrasive cleanser without bleach.
1. Prepare a germicidal solution according to the manufacturer's instructions. Use AirKem A-33, available from Ecolabs, Inc., 370 Wabasha, St. Paul, MN 35102 (phone: 1 800 247-5362), or from GAYMAR, product catalog MTA33.
  2. Drain the pump.
  3. Connect hose set together.
  4. Fill the reservoir to the Heating water line on the back of the reservoir.
  5. Select the 95°F (35°C) temperature setpoint on the keypad.
  6. Start the T/Pump, and circulate the solution for one hour.
  7. Drain the solution and refill the pump with clean water.

NOTE: In a home environment, perform only step 2 and the refill instructions in step 7.

## Pads / Accessories

Only use Mul•T•Pads®. The unique button design allows optimal water flow and provides trouble-free operation when the pad is folded. This reduces the number of different sizes of pads your facility must keep in inventory.

The Mul•T•Pads with Klik-Tite® connectors can be interconnected to provide therapy to more than one body site at a time (Figure 1B, page 4). Refer to Catalog Descriptions on page 5 for a list of various pads and ordering information.

PREVENTIVE  
MAINTENANCE / SERVICE

 DANGER

Risk of electric shock. Disconnect power before servicing.

 WARNING

Only qualified medical service personnel should repair the T/Pump in accordance with the Service Manual. Improper repair may result in death or serious injury, equipment damage, or malfunction.

Refer to functional check. To obtain a copy of the Service Manual, contact your local dealer or Gaymar's International Department or visit our web site [www.gaymar.com](http://www.gaymar.com).



FUNCTIONAL CHECK

Operating  
Temperatures &  
Over-Temperature  
Safety Circuit Check

This section provides a check of the T/Pump's temperature control, and over-temperature safety circuit. Follow the steps in this section carefully, paying particular attention to each step, and its expected result. If at any time the expected result can not be verified, press the On/Standby button to stop the test, then restart the procedure. If after a second attempt the expected result can not be verified, press the On/Standby button to stop the test, then unplug the T/Pump and call your dealer or Gaymar's Technical Service Department for assistance.

**⚠ WARNING**

- Only qualified service personnel should perform this Functional Check. Improperly following the test procedure may result in equipment damage.
- Do not perform this Functional Check with an empty reservoir. Damage to the T/Pump may result.
- Read through and understand each step before performing the test.

Interval

To assure optimum performance, dependability and safety, the following Functional Check should be performed once per year (or as specified in the facility's preventive maintenance program).

Required Tools

- TFC1 or equivalent (Thermometer with 30°F to 125°F (-2°C to 52°C) range with 2°F (1°C) accuracy.
- TPT9 is used to measure the temperature and the flow of the water entering the pad.
- Stop Watch for testing Over-Temperature Safety Circuit
- Mul•T•Pad

Note: To order a TFC1, TPT9, and Mul•T•Pad, contact your dealer or Gaymar's International Department.

Test Setup

Connect the T/Pump to the TPT9 and Mul•T•Pad as shown in Figure 6.

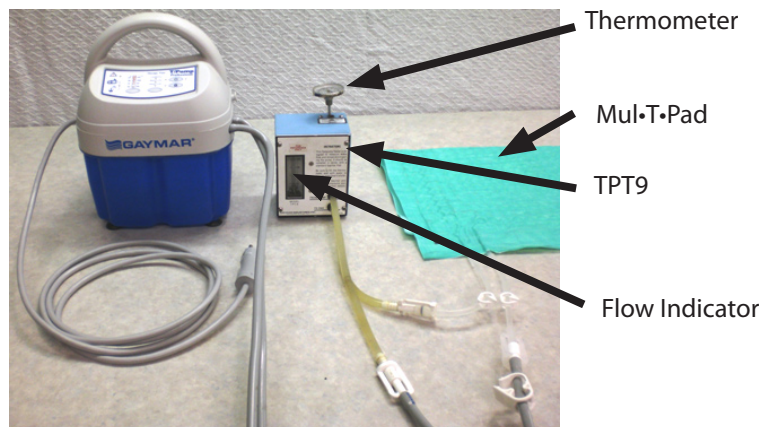



Figure 6: Functional Check Setup

Test Procedure

Note: Stay present for the full duration of the test to observe all readings and to prevent damage to the T/Pump.

1. Attach a pad to the connector hose (See Figure 6 on page 18). Then, unkink the pad and hose. Open the hose clamps.
2. Open the fill cap on top of the pump.
3. Fill with room temperature water to the Heating water line. 
4. Plug the T/Pump into a properly grounded Hospital Grade receptacle.
5. Press the On/Standby button.

The T/Pump performs its self test of the lights and audible alarm, with light pattern and short audible beep.

The T/Pump goes to Standby mode with only the Standby light on.

6. Press and hold the Temperature Setpoint button.
7. While still holding the Temperature Setpoint button, press the On/Standby button. Hold both buttons simultaneously for 3 seconds and then release.

The T/Pump gives a long audible beep, and the Warning light flashes.

The T/Pump goes into Operating Temperature Function Test mode, and the:

- T/Pump starts pumping with the Standby light on with a flow of 9 GPH minimum.
- 107°F (42°C) setting is selected.
- Continuous light is on.
- System disables the Wave feature to maintain a steady 107°F supply of water to the pad.

The T/Pump controls to 107°F (42°C) at the inlet to the pad for 15 minutes, the duration of the test.

8. After 12 minutes, verify with the TPT9 that the Temperature is at 107°F +/- 2°F (42°C +/- 1°C) and flow is 9 GPH minimum.

Note: If the T/Pump does not reach the temperature and flow, press the On/Standby button, unplug the unit, check the pad and hoses for kinks and start over.

9. After 15 minutes, observe that the T/Pump starts the Over Temperature Safety Circuit Test.

The T/Pump gives a long beep with the Warning light on. This signals the start of the Over Temperature Safety Circuit Test.

Note: If at any time the Function test needs to be stopped, press the On/Standby button.

Note: If the system does not shut down in an over temperature condition in 30 seconds, press the On/Standby button, then unplug the T/Pump. Contact your dealer or Gaymar's Technical Service Department for assistance

Telephone: 716 662-2551

10. Start the stop watch to make sure the Over Temperature condition is detected in 30 seconds.

WARNING: If this step is not followed, damage to the T/Pump may result.

- The T/Pump gives a long beep and flash of the Warning light.
- The pump stops. No water will be flowing to the pad.
- The Heater is turned on at 100% power with no flow.
- The 107°F (42°C) Setpoint light starts flashing.
- The 20-minute Cycle light starts flashing.
- When the T/Pump detects an Over Temperature Condition (temperature trip point of 115°F ±5°F [46°C ±2°C]), the T/Pump gives an audible beep and flashes the Warning light. The system then cycles and goes into Standby mode with the Warning light on.

11. When the Warning light turns on, stop the Stop-Watch.

12. Restart the Stop-Watch to make sure the T/Pump cools down to a point where the thermostat resets and the Warning light turns off in 60 minutes.

Or, to speed up the cool down go to step 13.

13. To speed up the cool down:


- a. Unplug the T/Pump.
- b. Refill the reservoir with room temperature tap water.
- c. Restart the unit in Cooling mode.

The system starts cooling down in Standby mode. The thermostat resets within 5 minutes.

The test is completed.

14. Shut down the T/Pump as described on page 10.

SPECIFICATIONS

	TP702
Classification	Class I equipment with Type BF applied part suitable for continuous operation. Not classified for protection against ingress of liquid. Not classified for use in the presence of flammable anesthetics.
Size (approx.)	11.5" x 8" x 8" 29.2cm x 20.3cm x 20.3cm
Weight	6.5 lbs (2.9 kg) when empty 9 lbs (4.0 kg) with unit filled with water to heating level
Reservoir capacity	93 oz (2.75 l) maximum
Flow rate	9 gph (34 lph) minimum with pad attached
Ambient operating temperature	60°F to 90°F (15.6°C to 32.2°C)
Environmental conditions for transport and storage	-20°F to 120°F (-28°C to 48°C) At uncontrolled RH
Temperature setpoints	TP702 Professional 107°F (42°C) 100°F (38°C) 95°F (35°C) 50°F (10°C)
Average temperature accuracy	±2°F at 107°F (±1°C at 42°C)
Maximum Contact Surface Temperature	107°F (42°C)
High Limit Safety Temperature	111°F to 118°F (44°C to 48°C)
Power cord	Modular: adaptable to Country of use
Current leakage	100 microamperes maximum
Ground resistance	0.5 ohm max
Electrical requirements Voltage (VAC) Frequency (Hz) Current (amps)	230±10% 50 Hz 2.0 amperes
Certifications	MEDICAL ELECTRICAL EQUIPMENT WITH RESPECT TO ELECTRICAL SHOCK, FIRE, AND MECHANICAL HAZARDS ONLY IN ACCORDANCE WITH UL 60601-1 AND ASTM F 2196-2002    IEC 60601-1-2

WARRANTIES

GAYMAR equipment and products are warranted against defects in material and workmanship under normal use, and operation from the date of purchase, for the time periods listed below for the respective equipment and products. Except for such warranty, GAYMAR disclaims all other expressed and/or implied warranties including, but not limited to, the implied warranties of merchantability and of fitness for a particular purpose.

PUMP

All labor performed and parts provided free of charge for a period of one (1) full year from the date of purchase, provided the equipment is returned with prior authorization prepaid to GAYMAR Industries.

PAD, SINGLE PATIENT  
USE

Free replacement of product where defects in materials and/or workmanship are evident at time of delivery, provided the product is returned with prior authorization prepaid to GAYMAR Industries.

PAD, REUSABLE

Free replacement of product where defects in materials and/or workmanship occur within 90 days from date of delivery, provided the product is returned with prior authorization prepaid to GAYMAR Industries.

PARTS

Defective parts will be exchanged free of charge where defects in materials and/or workmanship occur within 90 days from date of delivery, provided the parts are returned with prior authorization prepaid to GAYMAR Industries.

ENGLISH

The TP702 complies with EN60601-1-2: 2001 Second Edition  
(CISPR Classified as Class B, Group 1 ISM equipment)

Medical Electrical Equipment needs special precautions  
regarding EMC and needs to be installed and put into service  
according to the EMC information provided in the following  
pages.

Portable and mobile RF communications equipment can effect  
Medical Electrical Equipment.

**CAUTION !**

The TP702 should not be used adjacent to or stacked with  
other equipment. If adjacent or stacked use is necessary, the  
TP702 should be observed to verify normal operation in the  
configuration in which it will be used.

EMC INFORMATION

Guidance and manufacturer's declaration – electromagnetic immunity

The TP702 is suitable for use in the electromagnetic environment specified below.

The customer or the user of the TP702 should assure that it is used in such an environment.

Immunity test	IEC 60601 test level	Compliance level	Electromagnetic environment guidance
Electrostatic Discharge (ESD) IEC 61000-4-2	±6 kV contact  ±8 kV air	±6 kV contact  ±8 kV air	Floors should be wood, concrete, or ceramic tile. If floors are covered with synthetic material, the relative humidity should be at least 30 %.
Electrical fast Transient/burst IEC61000-4-4	±2 kV for power supply lines  ±1 kV for input/output lines	±2 kV for power supply lines  ±1 kV for input/output lines	Mains power quality should be that of a typical commercial or hospital environment
Surge IEC 61000-4-5	±1 kV differential mode  ±2 kV common mode	±1 kV differential mode  ±2 kV common mode	Mains power quality is that of a typical commercial and/or hospital environment
Voltage dips, short interruptions and voltage variations on power supply input lines IEC 61000-4-11	<5%Ut(95% dipUt) for 0,5 cycle 40%Ut (60% dop in Ut) for 5 cycles 70% Ut (30% dip in Ut) for 25 cycles <5% Ut (>95% dip in Ut) for 5 sec.	<5%Ut(95% dipUt) for 0,5 cycle 40%Ut (60% dop in Ut)for 5 cycles 70% Ut (30% dip in Ut) for 25 cycles <5% Ut (>95% dip in Ut) for 5 sec.	Mains power quality should be that of a typical commercial or hospital environment. If the user of the TP702 requires continued operation during power mains interruptions, it is recommended that the device be powered from an uninterruptible power supply or a battery.
Power frequency (50/60 Hz) magnetic field IEC 61000-4-8	3 A/m	3 A/m	Power frequency magnetic fields should be at levels characteristic of a typical location in a typical commercial and/or hospital environment.

Note:  $U_T$  is the a.c. mains voltage prior to application of the test level.

Recommended separation distances between portable and mobile RF communications equipment and the TP702.

The TP702 is intended for use in an electromagnetic environment in which radiated RF disturbances are controlled. The customer or the user of the TP702 can help prevent electromagnetic interferences by maintaining a minimum distance between portable and mobile RF communications equipment (transmitters) and the TP702 as recommended below, according to the maximum output power of the communications equipment.

Rated maximum output power of transmitter W	Separation distance according to frequency of transmitter		
	150 kHz to 80 MHz $d = 1,2 \sqrt{P}$	80 MHz to 800 MHz $d = 1,2 \sqrt{P}$	800 MHz to 2,5 GHz $d = 2,3 \sqrt{P}$
0,01	0,12	0,12	0,23
0,1	0,38	0,38	0,73
1	1,2	1,2	2,3
10	3,8	3,8	7,3
100	12	12	23

For transmitters rated at a maximum output power not listed above, the recommended separation distance  $d$  in meters (m) can be estimated using the equation applicable to the frequency of the transmitter, where  $P$  is the maximum output power rating of the transmitter in watts (W) according to the transmitter manufacturer.


NOTE 1 At 80 MHz and 800 MHz, the separation distance for the higher frequency range applies.

NOTE 2 These guidelines may not apply in all situations. Electromagnetic propagation is affected by absorption and reflection from structures, objects and people.

TP702 EMC Information

The TP702 is suitable for use in the electromagnetic environment specified below.

The customer or the user of the TP702 should assure that it is used in such an environment.

Immunity test	IEC 60601 test level	Compliance level	Electromagnetic environment - guidance
Conducted RF IEC 61000-4-6	3 Vrms 150 kHz to 80 MHz	3 Vrms	<p>Portable and mobile RF communications equipment should be used no closer to any part of the TP702 including cables, than the recommended separation distance calculated from the equation appropriate for the frequency of the transmitter.</p> <p style="text-align: center;">Recommended Separation Distance</p> $d = 1,2 \sqrt{P}$ $d = 1,2 \sqrt{P} \quad 80 \text{ MHz to } 800 \text{ MHz}$ $d = 2,3 \sqrt{P} \quad 800 \text{ MHz to } 2,5 \text{ GHz}$ <p>where P is the maximum output power rating of the transmitter in watts (W) according to the transmitter manufacturer and d is the recommended separation distance in meters (m).</p> <p>Field strengths from fixed RF transmitters, as determined by an electromagnetic site survey,<sup>a</sup></p> <p>Should be less than the compliance level in each frequency range.<sup>b</sup></p> <p>Interference may occur in the vicinity of equipment marked with the following symbol:</p> 
Radiated RF IEC 61000-4-3	3 V/m 80 MHz to 2,5 GHz	3 V/m	
<p>NOTE 1 At 80 MHz and 800 Mhz, the higher frequency range applies.</p> <p>NOTE 2 These guidelines may not apply in all situations. Electromagnetic propagation is affected by absorption and reflection from structures, objects and people.</p>			
<p><sup>a</sup> Field strengths from fixed transmitters, such as base stations for radio (cellular/cordless) telephones and land mobile radios, amateur radio, AM and FM radiobroadcast, and TV broadcast cannot be predicted theoretically with accuracy. To assess the electromagnetic environment due to fixed RF transmitters, an electromagnetic site survey should be considered. If the measured field strength in the location in which the TP702 is used exceeds the applicable RF compliance level above, the TP702 should be observed to verify normal operation. If abnormal performance is observed, additional measures may be necessary, such as re-orienting or relocating the TP702.</p> <p><sup>b</sup> Over the frequency range 150 kHz to 80 MHz, field strengths are less than 3 V/m</p>			

Guidance and manufacturer's declaration – electromagnetic emissions

The TP702 is intended for use in the electromagnetic environment specified below.

The customer or the user of the TP702 should assure that it is used in such an environment

Emissions Test	Compliance	Electromagnetic Environment
RF emissions CISPR 11	Group 1	The TP702 uses RF energy only for its internal function. Therefore, its RF emissions are very low and are not likely to cause any interference in nearby electronic equipment.
RF emissions CISPR 11	Class B	The TP702 is suitable for use in all establishments, including domestic establishments and those directly connected to the public low voltage power supply network that supplies buildings used for domestic purposes.
Harmonic emissions IEC 61000-3-2	Class A	
Voltage fluctuations/Flicker emissions IEC 61000-3-3	Complies	





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T/PUMPS® AND T/PADS®  
ARE MADE IN THE USA

## 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 Hospital and Rehabilitation Center (LHH) longer than the anticipated skilled nursing facility stay of 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) LHH~~ established the Short Stay hospital service code (LSS) effective January 1, 2014. This code designates residents expected to be discharged from ~~Laguna Honda Hospital and Rehabilitation Center LHH~~ to the community within 100 days of admission as a skilled nursing facility resident. Historically ~~Laguna Honda LHH~~ has had other ~~short stay~~ Short Stay codes such as LSA (Positive Care), LRH (Rehab), LRE (Respite), and LHP (Palliative Care) where residents’ stay is expected to be 100 days or less.

### PROCEDURE:

#### 1. ADMISSION

- a. The Admission and Screening Committee considers resident’s condition for admission using the Short Stay codes (LSS, LSA, LRH, LRE, LHP), based on the medical assessment 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~~ Short Stay code is used primarily for residents who are at a skilled nursing facility level of care and have a goal for a hospital stay of 100 days.  
~~would otherwise be coded as General SNF (LHG).~~
  - ii. The four other ~~short stay~~ Short Stay codes are used for residents on Palliative Care, Positive Care, Rehab, and Respite.
- b. When the resident has been admitted and identified as a Short Stay, 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: As with all residents who are admitted at- LHH Laguna Honda, ~~Discharge~~ planning for ~~Short Stay~~ residents designated with Short Stay codes begins immediately on admission. Specifically, for residents who are designated as Short Stay, ~~the~~ the following steps must occur between the 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~~The Medical Social Worker~~ 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.
  - ii. Resident Care Team (RCT) – An initial Resident Care Conference 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 shall establish a tentative discharge date and discuss the meaning of ~~short stay~~Short Stay plan with the resident and or responsible party during the first Resident Care Conference meeting.
  - iii. Utilization Management Nurse shall affix a blue sticker on the spine of the chart to denote a ~~short stay~~Short Stay resident.
- b. Day 15 – Day 45:
- i. Social Services Director and Patient Flow Coordinator – The Social Services Director and Patient Flow Coordinator shall track the ~~short stay~~Short Stay resident's progress with discharge planning and notify the RCT when the resident's length of stay reaches 45 and/or 75 days since admission. Either the Social Services Director or Patient Flow Coordinator will address issues or barriers that are delaying the original discharge plan; and will also inform the Resident Care Team Leadership member (Chief Medical Officer, Chief Nursing Officer or Assistant Hospital Administrator for Clinical Services) who can assist administratively with addressing the discharge barrier(s) or issue(s).
- c. Ongoing Weekly 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.
- Resident Care Team – Resident Care Teams shall discuss “Discharge Ready” ~~(per the Discharge Status Report)~~ residents who have active discharge plans during the weekly discharge huddle. Resident Care Teams shall prioritize the discussion of ~~short stay~~ Short Stay residents first.
- ~~Nurse Manager~~ Charge Nurse or designee – Nursing shall ~~establish a routine of completing weekly updated document weekly update(s) on the progress of the resident’s discharge plan. for short stay~~ Short Stay residents, specifically providing updates on the resident’s discharge progress.
- Any member of the RCT can inform their immediate supervisor or member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.

~~iii. Bi Monthly Hospital-wide Short Stay Huddle~~ Review:

- ~~This huddle review is facilitated by the Director of Social Services and the Utilization Management Nurse or designee, and attended by the Neighborhood Nurse Manager or designee and the Social Worker for residents who have been identified as Short Stay residents at the Community Reintegration performance improvement committee.~~
- ~~The intent of this discussion is to track that residents’ with Short Stay codes are and ensure that they are on track with their discharge plan. Any Short Stay resident that is not meeting the planned discharge timeline will be referred reviewed to Discharge Performance Improvement Team (PIT) to identify opportunities for improving discharge planning efforts.~~

d. Day 45:

- i. Social Services Director – The Social Services Director will notify the RCT via email when the Short Stay resident has reached the 45-day check-in milestone.
- ii. Resident Care Team – At 45 days after admission, Resident Care team shall assess resident’s discharge barriers to determine if the resident is on track for a timely discharge, as planned on admission and evaluated at the weekly discharge huddles. If the resident is not on track for timely discharge, the RCT

shall email the Patient Flow Coordinator to notify her/him regarding the resident's status, and update the care plan to reflect the change. The RCT shall update the discharge care plan to mitigate identified barriers to discharge and revise the estimated length of stay to 75 days, if appropriate.

~~ii.iii.~~ The Social Services Director or Patient Flow Coordinator shall any member of the RCT can inform their immediate supervisor or the appropriate member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.

~~iii.iv.~~ If the resident is likely to reside at ~~LHH Laguna Honda~~ for longer than 100 days, the RCT shall follow the steps outlined in Procedure # 3 - Change of Short Stay Codes.

e. Day 75:

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

~~ii.~~ The Social Services Director or Patient Flow Coordinator shall inform the appropriate member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.

~~— The Social Services Director or any member of the RCT can inform their immediate supervisor or member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.~~

f. Day 90 – Day 100:

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

~~ii.~~ The Social Services Director or Patient Flow Coordinator shall inform the appropriate member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.

~~iii.~~ The Social Services Director or any member of the RCT can inform their immediate supervisor or member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.

3. Bi Monthly Hospital-wide Short Stay Review:

- a. The intent of the Bi Monthly Hospital-wide Short Stay Review is to track the progress of discharge planning for short stay residents at 45 days, 75 days, 90 days and longer.
- b. This review is facilitated by the Director of Social Services and the Patient Flow Coordinator or designee, and attended by the Neighborhood Nurse Manager or designee, Utilization Management Nurse, ~~Primary Physician~~ and the Social Worker for residents who have been identified as Short Stay residents.
- c. The intent of this discussion is to track residents' with Short Stay codes and ensure that they are on track with their discharge plan. Any Short Stay resident that is not meeting the planned discharge timeline will be reviewed to identify opportunities for improving discharge planning efforts at the monthly Community Reintegration performance improvement committee.

#### 2.4. Change of Short Stay Codes

- a. ~~A significant change in the resident's health condition shall be the only reason for changing a resident's Short Stay~~ Short Stay code to a general SNF (LHG) hospital service code. A Short Stay code may be changed to a general SNF (LHG) hospital service code under the following situations:
  - 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 evaluate each ~~short stay~~ Short Stay code change request and meet with the Resident Care Team to discuss the resident's discharge plans and how the change in condition impacts those plans. The RCT Leadership Team members can also provide assistance and guidance to their respective discipline and RCT members to resolve discharge barrier(s) or issues(s).
  - 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, who will be responsible for updating the code from a ~~short stay~~ Short Stay code to LHG for general SNF services or to another ~~short stay~~ Short Stay, LSS.
  - iv. The Director of Social Services shall notify the Resident Care Team that the resident's discharge plan must change, and the Resident Care Team shall update the discharge plan with interventions to mitigate identified barriers to discharge.
- b. ~~Short stay~~ Short Stay residents who have completed ~~Rehab~~ Short Stay hospital services (LSA, LRH, LRE, and LHPLHR), but are not ready for discharge to the

community ~~may shall~~ have their ~~short stay~~Short Stay code changed to the LSS service code for continued tracking when relocated to a general SNF unit ~~(if applicable)~~, 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).

- c. The resident's length of stay begins anew ~~with each only if the readmission occurs greater than 30 days after discharge~~readmission. Residents readmitted as Short Stay will have 100 days to discharge from the date of readmission.
- 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 ~~to LHG.~~ -
- i. These factors will be recorded and monitored via the monthly Discharge Status Report.
- e. Residents who are not discharged within 100 days and have not had a significant change in health condition warranting a change in hospital service code shall ~~remain with the Short Stay code until discharge.~~be changed to LSS until discharge.

5. Reports and Metrics: Metrics described below track the effectiveness of discharge planning efforts for residents 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 shall perform a quarterly analysis of Short Stay residents for identification of learning and improved opportunities. For trend analysis, the following metrics shall be reviewed quarterly:
  - i. Number and percent of residents designated as.
  - 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. Performance Improvement Committees shall review CMS quality measure on Percentage of short-stay residents who were successfully discharged to the community (claims-based) during scheduled meetings.

~~e.d.~~ Quarterly analysis shall be performed to support performance improvement projects targeted toward specific sub-populations. Outcomes shall be reported to both the Community Re-integration Performance Improvement Team and the Utilization Management Committee and ultimately to the Performance Improvement and Patient Safety (PIPS) committee.

**ATTACHMENT:**

None.

**REFERENCE:**

None.

Revised: 16/07/12, 16/11/08 (Year/Month/Day)

Original adoption: 16/01/12



## **ABUSE PREVENTION, IDENTIFICATION, INVESTIGATION AND RESPONSE**

### **PHILOSOPHY:**

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

### **POLICY:**

1. ~~Laguna Honda~~LHH employees and volunteers shall strive to protect all residents from physical, psychological, fiduciary and verbal abuse and neglect.
2. ~~Laguna Honda~~LHH employees and volunteers shall comply with their obligation under law to refrain from acts of abuse or neglect and to report observed or suspected incidents of abuse and neglect.
3. ~~Laguna Honda~~LHH employees and volunteers shall respond to these incidents in a timely manner and report the incident to their direct supervisor, nurse manager or supervisor.
4. ~~Laguna Honda~~LHH Department Managers are responsible for monitoring staff compliance with this policy and ~~Laguna Honda~~LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.
5. Retaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

### **PURPOSE:**

1. To protect the resident from abuse or neglect.
2. To report incidents of abuse or neglect without fear of retaliation and in a timely manner.
3. To promptly investigate allegations of abuse or neglect.
4. To provide clinical intervention to prevent and minimize abuse or neglect.
5. To meet reporting requirements as mandated by federal and state laws and regulations.

**DEFINITION:**

1. Abuse means “the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.” (42 CFR 488.301) All residents, even those in a coma, may experience physical harm, pain or mental anguish. Abuse can include verbal, sexual, physical, financial and mental abuse.
  - a. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
  - b. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
  - c. Physical abuse, includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
  - d. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.
  - e. Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.
2. Neglect means “failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.” (42 CFR 488.301)
3. Misappropriation of resident property means “the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.” (42 CFR 488.301)
4. Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room against the residents' will, or the will of legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs.
5. Injury of unknown source/origin is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point in time or the incidents of injuries over time are suspicious in nature.

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

## **PROCEDURE:**

### **1. Screening of Potential Employees**

#### **a. Criminal Background Checks**

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

#### **b. Experience and References**

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

### **2. Education**

#### **a. Employee and Volunteer Education**

- i. New employees/volunteers, including transfers or inter- facility reassignments to ~~Laguna—HondaLHH~~, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement “Dependent Adult/Elder Abuse Prohibition and Reporting Requirement” shall be kept in the employee’s/ volunteer’s personnel file.
- ii. New employees/ volunteers, including transfers or inter- facility reassignments to ~~Laguna—HondaLHH~~, shall, as a condition of employment, participate in “The Abuse Prohibition/Prevention Program”, which includes the following:
  - Facility orientation program on residents’ rights, including confidentiality, preservation of dignity, recognizing and reporting of abuse without fear of retaliation, lost/stolen property, and misappropriation of resident funds;

- SMART training provided to new ~~Laguna Honda~~LHH staff;
  - Review of the following policies and procedures that support the overall program:
    - LHHPP 22-03 Resident Rights
    - LHHPP 21-04 HIPAA Compliance
    - ~~LHHPP 22-03 Resident Rights~~
    - LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
    - LHHPP 22-08 Threats of Physical Violence to Residents
    - LHHPP 22-10 Management of Aggression and Hostility
    - LHHPP 22-11 Patient/Resident Freedom from Abuse on Social Media
    - LHHPP 24-06 Resident Suggestions and Complaints
    - LHHPP 73-05 Violence in the Workplace-Zero Tolerance
  - Annual in-service education provided by the ~~Quality Management-QM~~ Nurse Educators to all employees, which includes a review of residents' rights, abuse prohibition/prevention, HIPAA compliance including use of social media and resident and employee freedom from retaliation when reporting abuse allegations.
  - Nursing Education provides additional abuse prevention training to all nursing staff, including recognition of potential signs of abuse including catastrophic reactions in residents, and recognition of factors that may contribute to abuse such as employee stress and burnout.
- b. Employees are obliged to report any reasonable suspicion of abuse against a resident to a law enforcement agency. Employees shall be notified of their reporting obligations during the new employee orientation and annually during residents' rights and abuse prevention in-services. Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident to a law enforcement agency during the new employee orientation and annually during residents' rights and abuse prevention in-services.
- c. Information on employee rights, including employee rights, including the right to file a complaint with the State Survey Agency if anyone at the facility retaliates

against an employee who files a report of a reasonable suspicion of a crime committed against a resident of the facility to a law enforcement agency, shall be posted in the ~~Human Resources~~HR Department. Posting will also encourage the employee to file a complaint with the ~~Human Resources~~HR Department in the event of retaliation.

d. Resident Education

- i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.
- ii. A listing of Residents' rights shall be posted on each unit.

### 3. Prevention

- a. Staff and families are provided with information on how and whom they may report concerns, incidents and grievances (see Employee and Volunteer Education).
- b. Staff shall be trained in Safety Management and Response Technique (SMART) techniques, which includes components on dealing with residents' aggressive behavior and catastrophic reactions.
- c. Staff conduct resident assessments, develop care plans, and monitor residents needs and behaviors that may lead to neglect or abuse (see "Resident Assessment and Care Planning").

### 4. Identification: Signs of Possible Abuse

- a. The following signs may alert ~~Laguna Honda~~LHH staff to possible resident abuse and indicate the need for immediate and further investigation:
  - i. Statements from a resident alleging abuse (including unreasonable confinement) by staff or another resident;
  - ii. Sounds that suggest physical or verbal abuse;
  - iii. Repeated resident "accidents," unexplained contusions or abrasions, injuries or bruises of unknown origin in a suspicious location;
  - iv. Illogical accounts given by resident or staff member of how an injury occurred;
  - v. Changes in resident personality or behavior, such as from pleasant to angry or from even-tempered to dejected or depressed; from easy-going to anxious,

- especially around a certain person, and especially if reluctant to give information;
- vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;
  - vii. Resident-to-resident altercations.

## **5. Protection: Staff/Volunteer Intervention**

- a. In the event that an employee/volunteer
  - i. Observes abuse,
  - ii. Suspects that abuse has occurred,
  - iii. Observes resident-to-resident altercation,
  - iv. Identifies an injury of unknown source/ origin,
  - v. Learns about an allegation of abuse or neglect of any ~~Laguna Honda~~LHH resident, and/or is the first person to learn of a resident-to-resident altercation, that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.
- b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:
  - i. In the event of alleged employee to resident abuse, the responsible manager shall reassign the employee who is being investigated to non-patient care duties or place the employee on administrative leave if non-patient care duties are not available at the point the manager was notified of the allegation. These measures shall be in place until the investigation is completed.
  - ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.
- c. The responsible manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.
- d. Upon receiving a report of alleged abuse, the attending or on-call physician shall promptly perform a physical exam. The physician shall record in the progress

notes of the resident's medical record the history of abuse as relayed, any findings of physical examination and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

- e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.
- f. The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".

## 6. Reporting Protocol

- a. The facility mandates all staff to report suspected abuse to the local Ombudsman office as required by State law.
- b. The facility requires the employee, manager, agent or contractor of the facility to report to the Sheriff's Department any reasonable suspicion of a crime committed against a resident of ~~Laguna Honda~~LHH Hospital.
  - i. If the criminal incident resulted in serious bodily injury to the resident, the Sheriff's Department must be notified immediately, no later than 2 hours after the suspicion is formed.
  - ii. Criminal incidents not resulting in serious bodily injury to the resident be reported to the Sheriff's Department within 24 hours of the time the suspicion is formed.
- c. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall:
  - i. Immediately notify the attending or on-call physician of the alleged abuse;
  - ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker;
  - iii. Notify within 24 hours the Medical Social Services Worker and Quality Management~~the QM department~~ by phone or e-mail.

- d. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.
- e. If an abuse allegation involves a ~~Laguna Honda~~LHH staff person, the nursing supervisor shall notify ~~Human Resources~~the HR department and the staff person's immediate supervisor within 24 hours.
- f. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician, the San Francisco Sheriff's Department, and the ~~Laguna Honda~~LHH Administrator On Duty.
- g. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of staff to resident abuse, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to the Sheriff's Department. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.
- h. In cases of alleged or factual rape the following steps must be taken:
  - i. Facility staff must immediately notify the San Francisco Sheriff's Department (Ext. 4-2319; 4-2301)
  - ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.
  - iii. At the San Francisco Rape Treatment Center the resident will be interviewed, specimens will be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.
  - iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.
  - v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.
- i. This policy designates the Director of Quality Management as the primary mandated reporter for LHH, Laguna Honda Hospital and Rehabilitation Center (Laguna Honda). The Director of Quality Management or designee ensures that



allegations of resident abuse are reported to the Ombudsman, Sheriff's Department, and the California State Licensing and Certification Office.

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

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

## 7. Investigation

- a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).
- b. If an abuse allegation involves a ~~Laguna Honda~~ LHH employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or place the employee on administrative leave, pending completion of the investigation. The interim reassignment or administrative leave will be in place until the Nursing and ~~Human Resources~~ HR Departments complete their investigations and confer on their findings. The employee shall be formally notified of the outcome of the investigation and future employee assignment.
- c. If an abuse allegation involves a ~~Laguna Honda~~ LHH employee and the preliminary investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by the ~~Human Resources~~ HR Department. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:
  - i. Severity of the allegation,
  - ii. Circumstances of the case per the investigation, and
  - iii. Prior disciplinary and employment history.
- d. The ~~Department of Quality Management~~ QM department shall forward investigation documents related to the abuse allegation involving ~~Laguna Honda~~ LHH staff to the ~~Laguna Honda~~ LHH ~~Department of Human Resources~~ HR ~~department~~. The ~~Laguna Honda~~ LHH ~~Human Resources~~ HR ~~d~~Department shall

conduct an independent investigation of any abuse allegation involving Laguna Honda LHH staff whenever the investigating party determines in the Summary of Alleged Abuse Preliminary Report form that abuse is substantiated.

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

~~f. The Chief Nursing Officer (CNO) or designee shall conduct an independent investigation of any abuse allegation involving Registry staff whenever the investigating party determines in the Summary of Alleged Abuse Preliminary Report form that abuse is substantiated. The Registry Office shall be informed about the allegation, and asked not to return the assigned Registry staff to work at LHH.~~

~~g.f.~~ If an employee or non-employee is identified as a suspect, the nursing supervisor or nurse manager shall contact the Sheriff's Department. The nursing supervisor or manager and the Sheriff's Department shall jointly carry out the investigation and initiate action to protect the resident.

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

## 8. Forms Completion and Submission

- a. The reporting employee shall complete the Unusual Occurrence report and "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), or designate the Medical Social Worker to complete form SOC 341. Both reports must be submitted to the Department of Quality Management. (Refer to Laguna Honda LHH designated site for copies of electronic forms related to Abuse Investigation).
- b. The investigating supervisor/manager conducting the investigation into resident abuse or neglect shall verify that the Unusual Occurrence and Report of Suspected Dependent Adult/Elder Abuse forms have been completed and submitted to the Department of Quality Management.
- c. The SOC 341 shall be faxed to 415-751-9789 by the reporting employee and the fax verification submitted to Quality Management the QM Department.
- d. In cases of resident-to-resident altercation, the investigating supervisor/manager shall complete the "Abuse Preliminary Inquiry Form-Resident to Resident" form and submit the form, along with any attachments, to the Department of Quality Management.

- e. In cases of alleged resident abuse by staff or visitor, the investigating director/manager conducting the inquiry shall complete an "Abuse Preliminary Inquiry Form-Staff to Resident" form or "Abuse Visitor to Resident Abuse Investigation" form and submit the form, along with any attachments to the ~~Department of Quality Management~~QM department. Final conclusion is determined by the Nursing Director.
- e.f. In cases of injury on unknown origin, the investigation supervisor/manager shall complete the "Abuse Preliminary Inquiry Form - Injury of Unknown Origin" form and submit the form, along with any documents, to the ~~Department of Quality Management~~QM department.
- f.g. ~~Quality Management-QM~~ staff shall submit form SOC 341 to the Ombudsman Office via fax (415-751-9789) when fax verification by the reporting employee is not received by the ~~Quality Management-QM d~~Department staff.
- g.h. ~~Quality Management-QM~~ staff shall provide a copy of the form SOC 341 to the Sheriff's Department.

## 9. Resident Assessment and Care Planning

- a. In cases of allegations of abuse or resident-to-resident altercation, the nurse manager or charge nurse, with input from other RCT members, shall take the lead in assessing and updating the residents care plan(s). Considerations for care planning may include the following:
- i. Short-term and long-term measures to provide the resident with a safe and secure environment.
  - ii. Measures to mitigate the psychological impact of the incident.
  - iii. Identify Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.
  - iv. Physiologic factor(s) involved in this incident. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain? Did the resident have signs of an infection or delirium?)
  - v. Treatment that may have contributed to his/her behavior.
  - vi. Need for psychiatric evaluation.
  - vii. Environmental stimulus/factor(s) contributing to in this incident (excessive noise, crowded room).
  - viii. Ability to modify environment.

- ix. Likelihood of a repeat incident.
- x. What Interventions ~~to~~ can be implemented to minimize the risk of recurrence.
- xi. Need relocation or transfer to another level of care.

**ATTACHMENT:**

Appendix One: Sample Guidance for “Conducting A Thorough Investigation”

**REFERENCE:**

[LHPP 21-04 HIPAA Compliance](#)

LHHPP 22-03 Resident Rights

LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss

LHHPP 22-08 Threats of Violence to Residents by an External Party

LHHPP 22-10 Management of Resident Aggression

LHHPP 24-06 Resident Suggestions and Complaints

LHHPP 76-04 Violence in the Workplace – Zero Tolerance

LHHPP B 3.0 Nursing Policy - Resident Funds

Form: “Dependent Adult/Elder Abuse Prohibition and Reporting Requirement”

Form: Preliminary Investigation of Alleged Staff to Resident Abuse

Form: Preliminary Investigation of Resident to Staff Aggressive Behavior

Form: Preliminary Investigation of Resident to Resident Incident

Elder Justice Act of 2009

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05,  
07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 16/11/08 (Year/Month/Day)

Original adoption: 05/20/92

**APPENDIX ONE:**

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

**GUIDANCE TO CONDUCTING A THOROUGH INVESTIGATION**

1. Identify the type of reportable incident (injury of unknown source or alleged abuse).
2. If abuse is alleged, identify the type of abuse (i.e. physical, verbal, sexual, mental, neglect, involuntary seclusion, misappropriation of resident property).
3. If the reportable incident is an injury of unknown source:
  - a. Describe the injury.
  - b. Document the size, location, color, pattern and number of injuries.
  - c. What treatment was required and provided?
  - d. Document if the resident has had similar injuries.
  - e. Identify any diagnoses or medications that have the potential for placing the resident at risk for injury.
4. Consider and document the time of the last observation of the resident prior to the reportable incident. What was the resident's condition prior to the reportable incident? What was the resident's condition after the reportable incident?
5. If the reportable incident is a case of suspected abuse:
  - a. Examine the resident for any signs of injury.
  - b. Was there a change in the resident's "usual" demeanor?
  - c. Accurately describe the first signs of injury or any change in the resident.
  - d. Photograph any actual injury in a manner that will show a close-up view of the injury and will not include the resident's face or other identifying features. The staff taking the photographs should sign and date the photographs and document the name of the resident on the photograph.
6. Interview the person reporting the incident.
  - a. Was the incident reported timely?

- b. What allegedly occurred?
  - c. When and where did the alleged incident occur?
  - d. If abuse is alleged, has an individual been identified as the abuser?
7. Develop a list of known and possible witnesses to the reportable incident.
8. Interview staff, residents, and/or visitors, or anyone who has or might have knowledge of the incident under investigation.
- a. Interview staff assigned to the resident at the time of the alleged incident.
  - b. In addition, consider all possible witnesses such as housekeeping and dietary staff.
  - c. Interview staff on other shifts that may have seen or heard something, such as 24 to 48 hours prior to the identification of the reportable incident.
  - d. Attempt to narrow down the time of the alleged incident.
  - e. Interview the resident in the same room, or residents in the immediate vicinity where the reportable incident occurred.
  - f. Consider who may have seen or heard something and what they think could have happened.
  - g. Observe and document any unusual demeanor of the person being interviewed
9. Identify the cognitive status of the victim(s) and resident(s) determined to be witnesses.
- a. Are they alert and oriented and able to answer questions appropriately?
  - b. Can staff confirm the resident's ability to be an accurate reporter of the events?
  - c. If so, document the interview with the staff related to the reliability of the resident.
  - d. Review a copy of the resident's current MDS and the current plan of care, if applicable to the incident.
  - e. If the witness (resident or roommate) is not alert and oriented, but the facility is utilizing the resident's statement in the investigation, explain why the resident is considered an accurate reporter (i.e., he/she has a history of consistently providing accurate information).

10. Review and have documentation of the alleged abuser(s) schedule for the 48-hour period prior to and the day of the reportable incident.
  - a. When and where was the alleged abuser(s) working at the time of the incident? Be specific as to the hall, section, and room numbers. Review and compare the assignment and the witness statements for accuracy of pertinent dates, times, location, and persons present.
11. Review the alleged abuser(s) personnel record for a history of previous disciplinary actions, previous employment evaluations, background investigation, inservice record, and the status of the certification or license. Interview co-workers and/or residents to gain knowledge of their experiences with the alleged abuser(s).
12. Document any action(s) taken by the facility to protect the resident and to prevent possible retaliation during the investigation (maintain punch card reports to show alleged abuser(s) was suspended during the investigation).
13. Document any knowledge of bias between alleged abuser(s) and witnesses. What is the relationship between the witnesses and the alleged abuser(s) (i.e. professionals, friends, relatives, and enemies)? Is there a reason the witness would wrongfully accuse the alleged abuser?
14. Were agency personnel involved? Identify the name of the agency, the contact person, and the names, address, and phone number of the agency staff employee(s).
15. If the allegation involves alleged sexual abuse, did a nurse immediately examine the resident? Did the nurse document the findings? Document if a physician examined the resident and maintain a copy of the examination. Document specifically what immediate action was taken by the staff at the time of the alleged abuse, i.e., facility secured, notification of administrator, physician, responsible party, law enforcement, evidence secured (resident's clothing not removed, resident not bathed).
16. If the allegation involves neglect, attempt to identify the staff involved. How were they involved and what was the outcome to the resident? Maintain physical evidence related to the care of the resident in use on the day of the incident (i.e., written plan of care, communication tools used to direct care such as signs above the head of the bed, personal care records, CNA assignments sheets, facility communication sheets). Signed and dated copies of any forms or documents used in the care of the resident at the time of the incident. If applicable, review facility procedures if the incident may be related to unsafe technique. Review and maintain the manufacturer's recommendations related to the use of special equipment. Review and identify any nurse's notes or other facility records that may contain information

relative to the incident. What interventions were in place prior to the reportable incident?

17. If the allegation involves misappropriation of resident property, clearly identify the missing items and their approximate value. Document the immediate action taken, i.e. notification of law enforcement, and responsible party. Obtain copies of bills, charge slips, vendor receipts.
18. Facility Investigative File: At the onset of the investigation, begin compiling the investigative file, to be maintained as a record. A complete investigative file may contain/but is not limited to the following:
  - a. Reporting sheets completed by staff to internally report the incident (i.e. Incident or Unusual Occurrence Reports which are confidential reports under Section 1157 Code), as well as reporting documents such as the Preliminary Investigation forms as evidence of appropriate reporting to the State survey agency.
  - b. Witness statements for all witnesses, alleged abuser(s), and resident if applicable. Include written statements not only from everyone involved in the incident but also everyone who participated in any way in the investigation.
  - c. Any written documentation related to an actual injury, (i.e., nurses notes, social work notes on the day of the incident and any other related dates), as well as pictures of the actual injury that identify the resident by name only, signed and dated by the staff member taking the photographs.
  - d. Related physician's orders, such as an order for a particular transfer device, or for x-rays if there is evidence or suspicion of injury.
  - e. The Resident Care Plan signed and dated by staff to show the care plan that was in place at the time of the incident.
  - f. Documents that serve as instruction to CNAs related to the care of the resident.
  - g. Manufacturer's recommendations related to the use of special equipment.
  - h. Inservice material with sign-rosters for equipment in use at the time of the injury that may potentially be involved in the cause of the injury (i.e., lift, transfer equipment, etc.). Include inservice and orientation records that show the staff was trained on any equipment related to the injury.
  - i. The schedule for all staff on the unit at the time of the injury and 24 to 48 hours prior to the injury.
  - j. Assignment sheets for staff caring for the resident at the time of the incident.



- k. Documents that show action taken by the facility to protect the resident.
- l. Name(s) of agency personnel on duty at the time of the incident, if applicable. Include the name of the agency, the contact person, and the names, addresses and phone numbers of all agency staff employee(s).
- m. Documentation of disciplinary action of the alleged abuser(s) at the time of the incident and any other time during their employment with the facility. Include a copy of the background investigation prior to hire, and the current certification or license.
- n. Documentation of any notification/referrals made as a result of the investigation such Board of Nursing or law enforcement.

### **SUMMARY REPORT OF FACILITY INVESTIGATION**

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

### **REFERENCE SOURCE:**

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

## RESIDENTS' COUNCIL

### POLICY:

Laguna Honda Hospital and Rehabilitation Center provides residents a forum including space, promotion and coordination to attend in order to express concerns, issues and needs 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 decisions that affect resident care and quality of life at Laguna Honda.

### 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. Residents' Council generally occurs monthly.
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. Ensure recording of meeting minutes.

- vi. Maintain three most recent years of Residents' Council records.
  - vii. Forward meeting minutes to staff as identified below.
  - viii. Facilitate elections of officers as requested by Residents' Council
- b. Representative from Administration
- i. Acts as the communication liaison between Residents' Council Officers and hospital departments.
  - ii. Responds directly to questions and concerns related to hospital departments, operations and/or administration.
  - iii. Reports to the Executive Administration when further action is needed to facilitate and/or address communications.
  - iv. Reports on items related to hospital operations of interest to the Residents' Council.
- 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 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

7. The Residents' Council may 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.
9. Activity Therapy staff may review Residents' Council minutes with residents on their assigned units at the neighborhood community meetings, 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.~~

[Attachment A: Main Building Resident Council Bylaws](#)

**REFERENCE:**

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, 16/11/08 (Year/Month/Day)  
Original adoption: 07/12/18

Attachment A:

**Main Building Resident Council Bylaws,**

Presented and approved on May 17, 2007,

Updated on May 15, 2008,

June 17, 2010,

April 21, 2011

July 18, 2013

November 17, 2014

Bylaws:

1. The President (or designee) of Residents' Council should try to welcome and invite new residents to the Council within their first two weeks at LHH. All interdisciplinary team staff will encourage and facilitate resident's participation in the Residents' Councils.
2. Members of the Residents' Council include all interested residents.
3. Expected guests include:
  - a. Facilitator (Activity Therapy Supervisor)
  - b. Executive Assistant to the Executive Administrator
  - c. Executive Administrator (Ad. Lib)
  - d. Nursing representative
  - e. Ombudsman (2013)
4. Other invited guests:
  - a. The Residents' Council will refer the request for the presence of invited guests to the Executive Assistant who will invite the specified personnel.
  - b. Staff members or other individuals wishing to attend the Residents' Council and engage the Council must have that request approved by the appropriate Residents' Council President prior to the meeting.
  - c. 11/15/07: Guest speakers will be scheduled towards the end of meeting, after resident topics and issues are addressed.
5. The Residents' Council officers and their roles and responsibilities are:

- a. President: Responsible for the running of meetings and representing the interests of the Council between meetings.
  - b. Vice President: Assumes responsibilities in the absence of the President.
  - c. Past President: Acts as an advisor to the Council. The Past president is not elected, but assumes the role at the end of his or her term in office.
  - d. 3 Representatives: Support resident council efforts, attend scheduled meetings. (Amended on July 18, 2013: Representatives will represent the North, South and Pavilion residents.)
6. All officers are encouraged to attend scheduled meetings between Staff & Officers to address hospital business. (Added 3/19/09).
7. Elections for Residents' Council officers are held each June or as needed:
- a. Amended on April 21, 2011: The timeline for Resident elections are as follows:
    - i. March: Resident Council officers will make general announcement about upcoming election, ensure council body is aware of the process.
    - ii. April: Nominations will be announced, interested residents will either announce their candidacy there or express their interest to facilitator. It would be preferred that Representatives reside that elected neighborhood.
    - iii. May: Nominations will be finalized, afterwards a poster of the Candidates will be generated and distributed throughout the hospital.
    - iv. June: Entire Resident Council meeting will be dedicated to election.
      - When residents enter the room, volunteer resident(s) will provide incoming residents with an envelope with ballot inside. Staff will support in creating the ballots.
      - Candidates will have an opportunity to make a speech. Note: To qualify for speech time, resident must be previously nominated and written in the ballot. Write-in candidates will not have the opportunity to speak.
      - With staff and volunteer support, resident will complete ballot.
      - Tallying votes: 2 residents and former President and support staff will count the votes. Winner will be announced on that day.
      - New officers will begin their terms in July.

v. Campaigning:

- The only staff that can assist candidates in campaigning are Activity Therapy staff.

8. The term for Residents' Council office is 2 years (revised on 6/17/10).

a. Officers can serve multiple terms, they must not be consecutive terms. (Effective July 2013).

9. Topics of concern to the Residents' Council will be discussed at the meetings. If there is an issue which Residents' Council may wish to request a response from hospital staff, a motion is made to request such response. The motion is voted upon. If approved the president will ask the Executive Assistant to make the request for response to the appropriate department head.

10. Responses from department heads will be read and discussed at the Residents' Council meetings. The council will indicate its acceptance of the response or refer the issue back for additional action or response. The Executive Assistant is responsible for facilitating the additional communication between the councils and hospital staff.

11. Neighborhood rep (2013): Neighborhoods are encouraged to appoint a representative that will advocate for their neighborhood's unresolved business. These representatives will discuss the problems with Building representatives, so that neighborhood business can be dealt with directly and promptly. These representatives are also encouraged to attend Residents' council meetings. If neighborhood representatives cannot attend meeting, Neighborhood meeting minutes are forwarded to Resident Council officers.

12. Proxies (2013): If any resident can't attend a resident council, they can appoint any one to represent him as a proxy at the resident council meeting. This appointed proxy will have voting rights on behalf of the absent resident.

13. LCR (2014): Residents who are interested in attending Resident Council Meetings and need reminders or transport assistance will notify AT Dept. AT Dept will enter their names in the LCR clinic scheduling system.

## **RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC)**

### **POLICIES:**

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident's family, or surrogate decision-maker shall develop a comprehensive plan of care, based on the care team disciplines' assessments, that includes measurable objectives and a time table to meet the resident's medical, nursing, and mental health needs.
2. The Resident Care Plan (RCP) will be evaluated regularly, at a minimum of once every quarter, and revised as needed to serve as an essential resource for improved resident outcomes.
3. Most care problems require various professional disciplines working together in planning, implementing and evaluating interventions. The ~~Resident Care Team (RCT)~~ may care plan together in formal resident care meetings, in smaller less formal settings, in discussions over the telephone or by written communication.
4. A Resident Care Conference (RCC) will be conducted with the scheduled completion of an admission, quarterly, annual and significant change in condition MDS.
5. Special Review (SR) RCC's ~~are~~ shall be held when the review of specific care issues are clinically indicated.
6. Stable, ongoing resident needs and resident preferences are addressed on the Front Card (MR 318A). Unstable, alterable problems that require a more goal directed approach are addressed on the ~~Resident Care Plan~~ RCP (MR 318). Together they comprise the resident's care plan.

### **PURPOSE:**

To promote the resident's highest ~~practicable~~ possible physical, mental and psychosocial well-being.

### **PROCEDURE:**

#### **1. The Resident Care Team**

- a. ~~The RCT~~ is an essential component of the care planning process. The ~~Resident Care Team (RCT)~~ will include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include:



- i. Resident, family, significant other(s) and/or conservator
- ii. Nurse Managers (or designee) – Facilitator of Resident Care ConferenceRCC
- iii. Licensed Nurse
- iv. ~~Direct Care Giver~~ Nursing Assistant
- v. Attending Physician
- vi. Medical Social Worker
- vii. MDS Coordinator
- viii. Activity Therapist
- ix. Registered Dietitian

In the event that a special review meeting is necessary, at least two (2) appropriate team members from two different disciplines will attend of which one will be a nurse. The entire RCT will be notified of any care plan changes.

Consultative Members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

- Chaplaincy
- Clinical Nurse Specialist
- Psychiatrist/Psychologist/Psychiatric Social Worker/Psychosocial
- Occupational Therapist/SATS Counselor
- Quality Management
- Pharmacy
- Rehabilitation Services
- Dietary Technicians
- Peer Mentors
- Ombudsmen
- Any other consultants as needed

- b. The RCT will address resident care needs and preferences through assessment of the resident and the development and implementation of the ~~resident care plan~~ RCP.
- c. The RCT will address resident care needs through assessment such as the:
  - i. Minimum Data Set (See ~~HWP-LHHPP 23-02~~ Completion of Resident Assessment Instrument/Minimum Data Set-20-06-B)
  - ii. Admission assessments including but not limited to:
    - Physician History and Physical
    - Resident Social History Assessment (MR 703)
    - Nutrition Screening and Assessment (MR 121)
    - Admission Nursing Assessment (MR 321)
    - Comprehensive Pain Assessment (MR 337)
    - Behavioral Risk Assessment (MR 340)
    - Discharge Assessment (MR 711)
    - Pressure Ulcer Risk Assessment (MR 347)
    - Activity Therapy Assessment (MR 602)
    - ~~Smoking Assessment (MR 161)~~
    - RCT Pre and Post Elopement Event (MR 170) (Cross Reference LHHPP 24-22 Code Green Protocol)
    - Siderail Order Form (if appropriate) (MR 172)

## 2. Resident Care Conferences

- a. ~~Resident Care Conferences~~ The RCC will serve as the forum for interdisciplinary development and review of the care plan. Care plan review will be done:
  - i. Within 21 days of new admission
  - ii. On a quarterly schedule with the MDS
  - iii. Annually

- iv. With a significant change in resident status
  - v. With discharge planning
  - vi. Within 14 – 21 days of relocation to another unit in Laguna Honda LHH
  - vii. ~~As any need arises~~ Special Review(s)
- b. RCT members are to conduct their assessments prior to the ~~resident care conference~~ RCC. Members will prepare for the conference prior to the meeting. This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.
- c. The resident and or surrogate decision-maker will be informed of the meeting, date and time, ~~no later than one week prior to the scheduled meeting date~~. The resident will be encouraged to attend the care conference, unless contraindicated by the resident's condition. The social worker will contact the surrogate / conservator about the meeting date and time. The meeting will provide the resident/surrogate with the opportunity to express concerns and preferences.
- d. The ~~direct care giver~~ nursing assistant and assigned licensed nurse will be ~~present~~ present or provide information if unable to attend at the care conference and consultants will be invited as appropriate.
- e. The ~~Resident Care Team~~ RCT Meeting-Interdisciplinary Conference Note (MR 335) will be completed for each RCC.

### **3. Admission Care Plan**

- a. Is initiated by nursing within 8 hours on the day of admission
- b. It addresses the resident's immediate needs for safety, management of risks and medical attention.
- c. As resident preferences become apparent they are entered on the Front Card.
- d. Problems identified by the Resident Assessment Instrument (RAI), must be care planned within seven days of the completion of the comprehensive assessment.

### **4. Identifying and Writing the Problem Statement**

- a. Problems, needs, strengths and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive and ongoing assessments.
- b. Problem statements are resident focused and not staff focused.

- c. The statement may, but does not require the reason for the problem, (i.e. what the problem is related to “R/T”).
- d. The statement may include some, but not all, of the common observable signs and be described as “As Evidenced by (AEB)”.
- e. Problems with the same root cause or same interventions may, but are not required to, be grouped together.

## **5. Determining the Goal Statement**

- a. The goal statement indicates the outcome desired by the resident or surrogate decision-maker and aims at promoting or maintaining the resident’s highest practicable physical, mental and psycho-social well-being.
- b. Goals must be realistic, specific, reflect the problem, measurable and have a target date.

## **6. Developing Interventions**

- a. Interventions answer the questions:
  - i. “What can the team do to minimize the risk of a problem developing?”
  - ii. “What can be done to address the resident’s preferences?”
  - iii. “How can the resident’s goal be met?”
- b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions.
- c. Interventions reflect standards of current professional practice.

## **7. Evaluating Effectiveness of the Care Plan**

- a. Evaluation of the care plan requires accurate knowledge and analysis of the resident’s present status, and is documented in the summary notes.
- b. There is evidence that the goal has been met or that there is progress towards the goal.
  - i. If there is evidence or progress towards the outcome desired by the resident or surrogate decision-maker.
  - ii. If the evaluation indicates that the goal is not being met, the RCT must determine the cause for the lack of progress and make the necessary changes.

- c. Consideration by the RCT should include:
  - i. Identification of the problem. Is it an accurate reflection of resident's present status?
  - ii. Measurable and realistic goals.
  - iii. Appropriate interventions for each goal.
  - iv. What else can be done?
  - v. Additional information as appropriate.
- d. The evaluation of the effectiveness of the care plan is documented in
  - i. The RCT summary note
  - ii. The nursing weekly/monthly summary
  - iii. Discipline specific progress notes in the chart or electronic health record

**8. Behavioral Treatment Plans are a part of the Resident's Plan of Care and a copy is to be kept in the Care Plan Binder**

- a. These plans are developed by the interdisciplinary ~~Resident Care Team~~RCT members. Plan development may require specialized behavior treatment planning meetings. Planning discussion is documented by a summary special review meeting note.
- b. These plans are drafted by team members, most often the Social Worker, in consultation with a Psychologist or Psychiatrist, and or consultation with other key team members on different shifts.
- c. The ~~Resident Care Team~~RCT is to discuss behavior treatment plans with the resident and/or the resident's surrogate decision-maker when appropriate.
- d. Behavior Treatment Plans are revised as needed and discontinued when the target behavior no longer poses a problem.
- e. Behaviors identified for modification will be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

**9. Communication**

- a. ~~Nursing~~The (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) will coordinate all Special Review RCC meeting dates and times.

- b. The RCT will communicate with one another in a timely manner using the RCT clipboard, email, and text paging, as needed.
- c. The Behavior Monitoring Record (BMR) is a tool used by nursing all disciplines to ~~track document~~ resident behaviors so that the RCT ~~has chosen to observe~~ asmay evaluate the resident's response to the treatment plan.
- d. Changes that affect the resident's care or daily routine will be communicated to the resident/surrogate as soon as possible in the method that is most practical for the resident/surrogate and will be repeated as needed or provided in writing.

**ATTACHMENT:**

None.

**REFERENCE:**

LHHPP 23-02 Completion of Resident Assessment Instrument ~~(formerly 20-06B)~~

LHHPP 24-22 Code Green Protocol

Long Term Care Survey, June 2006 Edition

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08 (Year/Month/Day)

Original adoption: 92/05/20

## VISITING HOURS

### POLICY:

Residents' visitors shall be ~~accommodated as much as possible~~ accommodated, without compromising ~~safety~~ residents' care or ~~well-being~~ well-being.

### PURPOSE:

To encourage ~~visitors~~ visitation of residents while protecting resident rights and health needs.

### PROCEDURE:

1. ~~Regular~~ Recommended visiting hours are daily, from 10:00 a.m. to 9:00 p.m.
2. All visitors must check in and sign in at the lobby and the nursing unit neighborhood upon arrival. (Cross Reference: LHHPP 75-02 Public Access and Night Security).
3. If a resident's physician has determined ~~specified~~ that having visitors would not be in a resident's best interest on a given day, this should be explained to the family ~~(preferably by the physician)~~. When only family visits are permitted, friends should be so advised and not given entrance. (Cross Reference: LHHPP 75-03 Disorderly or Disruptive Visitors and LHHPP 75-10 Security Services Standard Operating Procedures Appendix H)
4. If isolation precautions ~~are~~ required in a resident's room or the care unit, visitors shall be advised of this by the unit's nursing personnel and instructed as to the necessary precautions. (Cross Reference: LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention)
5. If visitors object to any general restrictions or specific ones imposed on the resident's behalf, they should be referred to the Nursing Office for special consideration.
6. Exception to the above procedure maybe made to meet the individual needs of the resident by the neighborhood's Resident Care Team.

### ATTACHMENT:

None.

### REFERENCE:

LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines

LHHPP 75-02 Public Access and Night Security

~~None~~

LHHPP 75-03 Disorderly or Disruptive Visitors

[LHPP 75-10 Security Services Standard Operating Procedures Appendix H  
B14 Visitors Guidelines](#)

Most recent reviews: ~~12/09/25 (Year/Month/Day)~~

Revised: 92/05/20, 12/09/25, 16/11/08 (Year/Month/Day)

Original adoption: 88/01/22



## CLOSE OBSERVATION COACH USE FOR CLOSE OBSERVATION

### POLICY:

1. Nursing is responsible to provide close observation of residents when needed. The nurse manager/charge nurse in collaboration with Nursing Operations staff will allocate staff as coach to provide the appropriate level of supervision.

4.2. Resident behaviors that may require close observation include but are not limited to the following:

a. high risk for falls; high risk for elopement;

b. and harm to self or others

c. poor safety awareness with specified behaviors

d. other extenuating needs as determined by Resident Care Team (RCT) and the approval of Nursing Director/Nursing Operations;

e-d. other challenging potential or injurious behaviors.

2.3. Close observation measures are not intended for residents who are actively suicidal (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.

4. The use of a coach is intended as a short-term intervention while developing a long term plan for resident safety.

3.5. The Resident Care Team (RCT) RCT is responsible for the initial and ongoing assessment ongoing assessment of the need for close observation measures.

~~1. Nursing is responsible to provide close observation of residents when needed. The nurse manager/charge nurse in collaboration with Nursing Operations staff will allocate staff as coach to provide the appropriate level of supervision.~~

6. Coaches will provide continuous close observation of the resident and avoid any distractions, such as speaking in a non-business language or a language the resident does not understand, cell phone use, reading, sleeping, in order to maintain resident safety.

7. Laguna Honda PCA/CNA are expected to complete DNCR documentation for a resident receiving a coach.

4.8. The charge nurse will check resident condition every 2 hours and as needed.

**PURPOSE:**

To provide a therapeutic and physically safe environment with the appropriate level of supervision for residents who have been determined assessed to have safety needs that exceed routine care and intervention measures.

To aid in determining long-term interventions to help care for the resident safely.

**PROCEDURE:****1. Role of the RCT**

- a. If the RCT determines that a resident's behaviors and condition requires close observation, the RCT will do the following:
  - i. Assess the need
    - The RCT (at a minimum, the MD and RN) will review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.
  - ii. Develop an observation and intervention plan
    - Possible close observation measures may include, but are not limited to:
      - increasing the frequency of observation time periods
      - assignment of staff to provide close observation
        - (coach).
  - iii. Develop measurable goal/s related to the use of close observation.
  - iv. Implement the plan
    - The nurse manager/charge nurse will assign staff, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse will round every 2 hours for updates.
    - Any request for additional staff used as coach will be made through the Nursing Office.

When a resident's family member or significant other assists with the resident's care and observation, the care plan will reflect their participation and education. Nursing staff will maintain overall responsibility for the care provided to the resident, including appropriate education on safety

measures to be given to the resident, family and/or staff providing close observation of the resident.

v. Evaluate the plan (Focused Review)

- While close observation is implemented, the RCT shall meet weekly to:
  - Review any changes in resident's condition.
  - Assess effectiveness of current interventions.
  - Evaluate resident goals and the need for ongoing close observation.
  - The RCT shall summarize each meeting on the RCC form.
- The RCT and other consultants which may include Nursing Directors, Quality Management, Rehab, Psych and Pharmacy staff will conduct a Focused Review if a resident has required a coach to provide close observation greater than 30 days.
  - If no progress is made after 60 days of close observation, resident case shall be referred to clinical leadership for long term placement.
  - If after 60 days close observation continues to be required the RCT may decrease focused reviews to monthly while continuing efforts in seeking long term placement.

vi. Documentation (See [Appendix Attachment A](#) for table reference)

- The Coach Assignment Form shall be completed by the charge nurse or nurse manager and be given to the assigned coach and /or placed in one of the ~~the~~ coach binders located on each of the neighborhoods.
- The ~~caregiver-coach~~ providing the close observation shall document their observations of the resident's behavior each shift using the Data Collection Sheet: Coach Report.
- LHH PCA/CNA are expected to complete DNCR documentation.
- Observations documented by the coach on the Coach Report will be incorporated in the Weekly or Monthly Summary by the licensed nurse.
- The Weekly Coach Use Evaluation form is to be completed by the charge nurse on each shift.
- The Behavior Monitoring Record (BMR) will be completed every shift by nursing and other clinical staff as appropriate.

- The resident care plan (RCP) will be updated on an ongoing basis and will include interventions for addressing the safety needs of the resident, including the need for close observation.
- Each RCT meeting will be documented using the Focused Review Record and will include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.
- Education provided to the resident, resident's family or significant other as related to safety measures will be documented.

## 2. Role/Expectations of the Coach Providing Close Observation

- a. The coach provides ~~supervision for one or more residents who require~~ close observation for one or more residents. All coach staff that are LH employees, are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:
  - ~~i. Coaches will report~~ Reporting to the charge nurse at the start/end of their shift for endorsements.
  - ~~ii.~~ Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.
  - ~~iii.~~ Engaging the resident with goal-focused resident-centered interventions and ongoing activities.
  - ~~iii.~~ iv. Observation, reporting and documentation of resident behavior, including observation of factors that contribute to improving resident's behavior and/or contributes to agitating the resident.
  - ~~iv.~~ v. Provision of nursing care as normally expected of a coach, including feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, and skin care and 1 person pivot transfer. (Please cross reference Resident Activities of Daily Living Nursing P&P – D1 2.0 – copy of said P&P will be included in coach binder.)
  - ~~v.~~ vi. Participating May contribute to the weekly focused reviews, ~~contributing to plan of and plan of~~ care and communicating resident progress to RCT.
  - ~~vi.~~ vii. Transport/escort residents to internal/external scheduled appointments

~~vii-viii.~~ Other duties as assigned, including specific responses to certain needs of the resident.

~~viii-ix.~~ Registry coaches will perform all the duties as described in the roles/expectations section of the close observation P&P. Registry coaches may assist with the exception of the following LHH nursing assistant or licensed nurse with the following, but not perform independently:

- Feeding residents on a Specialized Feeding Plan
- Showering /bathing
- always be assisted by LHH PCA/CNA staff to provide resident with shower or bathing, and with any usageUse of any equipment or assistive devices such as mechanical lifts and tilt shower chairsfor which they have not been trained, LHH PCA/CNA are to assist registry coaches with the aforementioned tasks.

~~ix-x.~~ Ensure environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.

~~x-xi.~~ Coaches will not leave residents unattended under any circumstances, coaches are to use call light to summon for help.-or use ? spectralink

~~xi.~~ Cellular phone usage and sleeping while on duty is prohibited.

**ATTACHMENT:**

None

Attachment A: Coach for Close Observation Roles and Responsibilities

**REFERENCE:**

None.

Revised: 00/03/28;<sub>i</sub> 00/11/22;<sub>i</sub> 01/05/10;<sub>i</sub> 01/05/18, 09/06/09, 13/01/29, 16/11/08 (Year, Month, Day)

Original adoption: 98/11/16

**Attachment A: Coach for Close Observation Roles and Responsibilities**

<u>Role</u>	<u>Responsibility</u>
<u>LHH PCA/CNA</u>	<ul style="list-style-type: none"> <li>• <u>Responsible for all duties within their scope of practice for assigned resident</u></li> <li>• <u>Documents in <b>Coach Binder</b> and communicates resident behaviors to regular CNA and or team.</u></li> </ul>
<u>Registry Coach</u>	<ul style="list-style-type: none"> <li>• <u>Responsible for all CNA Duties except showering and using equipment without assistance.</u></li> <li>• <u>Documents in <b>Coach Binder</b> and communicates resident behaviors to regular CNA and or team.</u></li> <li>• <u>May assist LHH nursing assistant or licensed nurse but <b>not perform independently</b>:</u> <ul style="list-style-type: none"> <li>○ <u>feeding residents on a Specialized Feeding Plan</u></li> <li>○ <u>showering/bathing</u></li> <li>○ <u>use any equipment or assistive devices for which they have not been trained</u></li> </ul> </li> </ul>
<u>Regular CNA</u>	<ul style="list-style-type: none"> <li>• <u>Completes <b>DNCR</b> with input from Coach</u></li> <li>• <u>Communicates any behaviors to the Licensed Nurse to be documented in <b>BMR</b></u></li> </ul>
<u>Charge Nurse</u>	<ul style="list-style-type: none"> <li>• <u>Completes <b>Coach Assignment Form</b> for coach binder</u></li> <li>• <u>Completes rounds q 2 hours for updates</u></li> <li>• <u>Completes weekly <b>Coach Use Evaluation Form</b></u></li> </ul>
<u>Resident Care Team</u>	<ul style="list-style-type: none"> <li>• <u>Assesses need for Close Observation</u></li> <li>• <u><b>Weekly</b>: Focused review to evaluate continued coach need</u></li> <li>• <u><b>30 days</b>: Provides Special Review with Consultants</u></li> <li>• <u><b>60 days</b>: May refer to Clinical Leadership for placement</u></li> </ul>
<u>LHH Home Health Aide</u>	<ul style="list-style-type: none"> <li>• <u>Close observation</u></li> <li>• <u>Documents in <b>Coach Binder</b> and communicates resident behaviors to regular CNA and or team.</u></li> <li>• <u>DNCR Documentation completed by PCA/CNA</u></li> </ul>

## **ANTIMICROBIAL STEWARDSHIP PROGRAM MANAGEMENT IN ACUTE MEDICINE AT LAGUNA HONDA HOSPITAL**

### **PURPOSE:**

The purpose of this policy is to provide for an antimicrobial stewardship program (ASP) which aims to optimize appropriate selection of antibiotics, improve patient outcomes, reduce health care costs and antimicrobial resistance, and minimize adverse effects of antimicrobial use.

### **POLICY:**

1. The hospital shall support a robust antimicrobial stewardship program for both acute and skilled nursing units.
- 1.2. The antimicrobial stewardship program shall evaluate all antimicrobial prescriptions in the acute care unit and targeted antimicrobial prescriptions on the skilled nursing units.
- 2.3. The ASP shall adopt the most recent standards of antimicrobial stewardship when evaluating antimicrobial use (See Appendix A).
  - a. Empiric broad spectrum antibiotics (e.g. carbapenems, vancomycin, fluoroquinolones) should be reserved for situations in which narrower spectrum drugs are likely to fail. Empiric therapy should continue for no more than 3-4 days to prevent adverse effects and resistance.
  - b. Combination therapy should only be used for patients who have multi-drug resistant pathogens.
  - c. Once culture results and sensitivities are available, antibiotics should be narrowed to minimize drug resistance.
  - d. Serum antibiotic drug levels should be drawn to optimize efficacy and prevent toxicities for some antibiotics, including: vancomycin, aminoglycosides. Vancomycin – trough level 30 minutes before the 4th dose. Aminoglycosides – trough level 30 minutes before the 4th dose for conventional dosing, trough level 30 minutes before the 2nd dose for once-daily dosing. With improvement of the patient’s medical condition, IV antibiotics should be converted to oral agents to decrease health care costs and length of acute hospital stay. Patients will be discharged back to their previous ward with appropriate oral antimicrobials, if needed.
3. Antimicrobial stewardship team will be comprised of a physician (ID consultant), clinical pharmacists and the infection preventionist.

### **PROCEDURE:**

#### **1. Antimicrobial Stewardship Program Members**

- a. The ASP Team is comprised of a physician (ID infectious disease consultant), clinical pharmacists, a representative from nursing, and the infection prevention and control officer.

## 2. ACUTE

### a. Acute Physician:

- i. Orders antibiotic(s) giving an appropriate indication for use.
- ii. Obtains necessary cultures if indicated (e.g., urine, blood, sputum) prior to first dose of antibiotics.
- iii. Documents in the medical record rationale for antibiotic therapy and selection of agent(s).

### b. Pharmacist:

- i. Performs a medication reconciliation to ensure appropriate medications are being used (this includes review of previous medication list and allergy history).
- ii. Contacts physician to recommend alternative therapy, if appropriate (e.g., due to renal dysfunction or drug-drug interactions).

### c. **Both the physician and the pharmacist are responsible for the following:**

- i. Appropriate dosing of antimicrobials based on the patient's age, weight, renal function, site of infection, causative organism, pharmacokinetics and pharmacodynamics of the drug.
- ii. Routine monitoring of all appropriate laboratory studies, which may include CBC, renal and liver function tests, and drug concentrations.
- iii. Determination of the length of antimicrobial therapy, based on the patient's clinical status, the site of infection, and the causative agent.

## 3. SNF

### a. Physician:

- i. Orders antibiotic(s) giving an appropriate indication for use.
- ii. Obtains necessary cultures if indicated (e.g., urine, blood, sputum) prior to first dose of antibiotics.



- iii. Documents in the medical record rationale for antibiotic therapy and selection of agent(s).

**4. Antimicrobial Stewardship Team:**

- a. Shall utilize the most recent standards for antimicrobial stewardship when evaluating antimicrobial use. ~~See Appendix A.~~
- b. Develops criteria and protocols for monitoring and intervention.
- c. Communicates protocols to medical staff and provides education regarding antimicrobial stewardship.
- d. Monitors and evaluates antimicrobial prescribing.
- e. Contacts prescribers to recommend alternative therapy, dosage and/or duration of therapy -when appropriate.
- ~~f. as well as dosage and duration of treatment when appropriate.~~
- f. Reports results of monitoring to Infection Control Committee, Pharmacy and Therapeutics Committee and Performance Improvement Patient Safety (PIPS) Committee.

**ATTACHMENT:**

Appendix A: Standards for Evaluating Antimicrobial Use

**REFERENCE:**

CDC. The Core Elements of Antibiotic Stewardship for Nursing Homes. Atlanta, GA: US Department of Health and Human Services, CDC; 2015. Available at: <http://www.cdc.gov/longtermcare/index.html>

**American Hospital Association**

American Society of Health-System Pharmacists' (ASHP). A Hospital pharmacist's Guide to Antimicrobial Stewardship programs.2010.  
<Http://www.ashpadvantage.com/stewardship>

Rybak M, Lomaestro B, Rotschafer J et al. Therapeutic monitoring of Vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. Am J Health-Syst Pharm. 2009; 66:82-98

Dellit T, Owens R, MCGowen J et al. Infectious Disease Society of America and Society for Health Care Epidemiology America Guidelines for Developing an Institutional Program To Enhance Antimicrobial Stewardship. CID 2007:44 (15 January)

University of California, San Francisco. Antibiotic Management for Critically Ill patients. 2005. [http://clinicalpharmacy.ucsf.edu/idmp/guide\\_home.htm](http://clinicalpharmacy.ucsf.edu/idmp/guide_home.htm)

Revised: 16/11/08 (Year/Month/Day)

Original adoption: 10/12/03

## **APPENDIX A**

### Standards for Evaluating Antimicrobial Use

1. Empiric broad-spectrum antibiotics (e.g. carbapenems, fluoroquinolones) are reserved for situations in which narrower-spectrum drugs are likely to fail. Empiric therapy should continue for no more than 3-4 days to prevent adverse effects and resistance.
2. Combination therapy are used for patients who have multi-drug resistant pathogens.
3. Antibiotics are narrowed based on culture results and sensitivities to minimize drug resistance.
4. Serum antibiotic drug levels are drawn to optimize efficacy and prevent toxicities for some antibiotics, including: vancomycin, aminoglycosides.
5. With improvement of the patient's medical condition, IV antibiotics are converted to oral agents to decrease health care costs and length of acute hospital stay. Patients will be discharged back to their previous ward with appropriate oral antimicrobials, if needed.

# CARING FOR THE DECEASED, USE OF MORGUE, AND PROVISION OF DEATH CERTIFICATES

## POLICY:

LHH Hospital and Rehabilitation Center (LHH) maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the Zuckerberg San Francisco General Hospital (ZSFG) Morgue. Admitting & Eligibility (A&E) and Nursing Departments shall collaborate to release and transfer decedents in a timely manner.

## PURPOSE:

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

## PROCEDURE:

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

<u>a. Notification of Death</u>	<u>Responsible Party</u>
Family / Guardian	Physician who pronounced death
Mortuary	Family or Legal Guardian, Nurse, or Admissions & Eligibility (A&E) staff
<u>b. Funeral Arrangements</u>	<u>Responsible Party</u>
Routine	Family or Legal Guardian
Public Administrator / Medical Examiner	A&E

### 2. Guidelines for the Completion of the Required Forms

<u>a. Documentation</u>	<u>Responsible Party</u>
<del>Death Registry</del>	<del>Medical Records</del>
Death Certificate	Medical Staff
Release Form	Completed by Mortician / Public Administrator
Deceased Resident's <del>Registry book</del>	<del>A&amp;E (Monday - Friday 8a.m. - 5 p.m.)</del>
<u>Morgue Data Base</u> <u>Deceased Registry</u>	Nursing

Office/~~A&E (Monday-Friday 5:00pm-  
8:00am, Weekends and Holidays)~~

Documentation

Responsible Party (continued)

Transfer Authorization Form \_\_\_\_\_ Mortician  
Application/~~permit~~  
~~Permit~~ for Human A&E Staff  
Remains through Electronic  
Death Registry System (EDRS)  
(~~if~~ decedent is still in the morgue  
after 8 days)

**~~3. Releasing Remains to Morticians~~**

- ~~a. During regular business hours (8AM-4PM, M-F), A&E staff are responsible for obtaining release from the family or conservator and/or examiner's office to authorize release of the body; and the mortuary to complete the death registry entry by writing the date, time of pick up, name of mortuary and name of mortuary attendant.~~
- ~~b. Evenings (after 4PM), weekends and holidays, nursing staff are responsible for obtaining release and assuring death registry is completed. Release forms received by the Nursing Office shall be placed in the death registry and forwarded to A&E for filing.~~
- ~~c. A & E retains a copy of the release form in the resident's A&E file.~~
- ~~d. Mortician signs in, writing date and time in LHH Death Registry book.~~
- ~~e. Mortician places the Release Form (from a family member or from LHH A&E) into the LHH Death Registry book.~~
- ~~f. Release of deceased requires a Release Form (see Procedure 3b) even if the Death Certificate must wait for physician signature.~~
- ~~g. Mortician shall present Transfer Authorization Form at time of release of body.~~
- ~~h. The A&E or Nursing staff receiving the Transfer Authorization Form shall sign the form and submit to A&E for filing.~~

**4. Death Certificate**

- a. Health Information Services (HIS) transfers the death certificate into the EDRS to the mortuary or vice versa. HIS contacts the physician to obtain the signature on

the death certificate and retains a copy of the death certificate on file. ~~A&E presents the original Death Certificate to the mortician and retains a copy for A&E files.~~

- b. If the resident expires over the a weekend, in the evening hours or holidays (between the hours of 5 p.m. Friday and 8 a.m. Monday):
  - i. Signing the Death Certificate shall wait until the care unit attending physician/designee is available.
  - ii. Under exceptional circumstance, if the family of the deceased or legal representative or mortician insists on immediately receiving the Death Certificate, the on call house night/weekend physician may sign the Death Certificate using his/her own signature and printed name and California Medical License #, but the on call the house night/weekend physician shall print or type the care unit attending physician's name in the appropriate signature block.

## **5. Morgue Monitoring**

**5. Morgue Monitoring: Laguna Honda Nursing and A&E department uses the Morgue Data Base (MDB) to document final disposition of the deceased and to monitor the morgue capacity.**

- a. Laguna Honda Hospital and Rehabilitation Center (LHH) maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the ZSFG morgue.
- b. A&E and Nursing departments shall collaborate to release and transfer decedents in a timely manner.
- c. Nursing Ops shall be responsible for data entry of resident information in the morgue database (MDB). A&E shall be responsible in monitoring the MDB for morgue capacity and accuracy.
- d. **Guidelines for the Completion of the MDB and Required Forms: Nursing Ops shall enter data to MDB when the resident's body is transferred to the morgue or picked up by the mortuary or examiner's office.**
  - i. **Steps for creating MDB record:**
    - Type in last name of Resident.
    - Select resident from drop down box and click on select button to display record.

- To complete entry select boxes to indicate if resident was picked up from Neighborhood or transferred to LHH morgue. If picked up from Neighborhood, name of mortuary and date of pick-up from drop down menu. If transferred to LHH morgue, select drawer number locations.
- Old Morgue drawer location numbers: Drawers O1-O12
- New Morgue drawer location numbers: H15 – H20

**e. Forms and Responsible Staff:**

- i. MDB Record printed from MDB and signed by Mortuary attendant picking up the decedent – Nursing Ops
- ii. Nursing Ops or designee shall scan MDB records to A&E. Original forms shall be placed in a designate A&E box located in the nursing office and shall be picked up by A&E staff.

**e.f. MDB Monitoring:**

- i. The MDB shall be monitored and updated by the nursing office and A&E.
  - ii. A&E Census Desk shall monitor the MDB daily to check number and status of decedents remaining in the morgue.
- g. Transfer to ZSFG due to overcapacity or autopsy: During normal business hours A&E Manger or designee shall arrange transport of decedents(s) to ZSFG or the Medical Examiner’s office. During non-business hours, weekends and holidays, Nursing Ops shall arrange transportation to ZSFG or the Medical Examiner’s office.
- h. The A&E Manager or designee shall notify the Chief Nursing Officer (CNO) and Director of Social Services if the morgue is nearing capacity (16 decedents).
  - i. Social services shall contact families to determine which decedents can be promptly transferred to mortuaries ~~immediately~~.
  - j. A&E Manager or designee shall contact the PA to expedite transfer of cases. If the Medical Examiner’s office has accepted jurisdiction, the A&E manager or designee shall request expedited pick-up.
  - k. The CNO or designee shall identify decedents to be transferred to ZSFG and contact ZSFG Morgue to arrange transfer.

**l. Transportation Arrangements due to overcapacity:**

- i. A&E contacts Green Street Mortuary for availability and quote

- ii. A&E completes RPO to Materials Management (Requires signature from Chief Financial Officer (CFO) or designee.
- iii. A&E finalizes pick-up/drop-off arrangements with Green St. and ZSFG morgue attendant.
- iv. A&E contacts CNO or designee with transfer arrangement information
  - ~~a. The Morgue data base is monitored and updated by nursing and A&E.~~
  - ~~b. A & E checks the morgue database monthly to determine whose remains have been picked up and those decedents who remain in the morgue.~~
  - ~~c. A & E shall notify the Chief Nursing Officer and the Director of Social Services if the morgue is nearing capacity (16 decedents). If the decision is made to transfer decedents, the following procedures shall be implemented:
    - ~~i. Request transfer of the decedent(s) to ZSG Morgue or Medical Examiner Morgue.~~
    - ~~ii. Fax a Face Sheet to the transport service. Retain evidence of successful fax.~~
    - ~~iii. During normal business hours A & E shall arrange transport of decedent(s) to ZSFG or Medical Examiner morgue.~~
    - ~~iv. At all other times (evenings, weekends and holidays) the Nursing Office shall arrange transport to ZSFG or Medical Examiner morgues.~~~~

**ATTACHMENT:**

None.

**REFERENCE:**

MSPC C01-01 Patient Expiration

NPP D8.0 Post Mortem Care

LHHPP 24-11 Notification of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death

Revised: 15/07/14, 16/09/13, 16/11/08 (Year/Month/Day)

Original adoption: 03/05/08



## GIFT FUND MANAGEMENT

### POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (~~LHH~~~~Laguna Honda~~) to maintain a gift fund for the purpose of receiving all gifts, donations and contributions of money, stocks and/or other financial donations made for the general benefit and comfort of ~~Laguna Honda~~~~LHH~~ residents/patients in accordance with the San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds).

All expenditures from the gift fund shall be made for the purposes for which the gift or donation was originally made.

### PURPOSE:

The purpose of this policy is to provide guidance to effectively manage the ~~G~~gift ~~F~~fund and to ensure oversight and accurate disbursements.

### PROCEDURE:

#### 1. Donations and Gifts:

- a. Grant codes for cash gifts have been established for the general benefit and comfort of patients as described in Appendix A.
- b. In the event a donation is made for a purpose/intent outside of the existing established grant codes, a new grant code may be established with the authorization of ~~Laguna Honda's~~~~LHH's~~ Executive Administrator and Chief Financial Officer (~~CFO~~). At the discretion of the Gift Fund Committee, a new grant code in the name of a donor may also be created in honor of the donor.
- c. The process for donation(s) or gift(s) made to ~~Laguna Honda~~~~LHH~~ is as follows:
  - i. If a donation is made by cash or check, the staff person who receives the donation shall deliver it to the ~~Laguna Honda's~~~~LHH's~~ ~~Chief Financial Officer (CFO)~~~~CFO~~/designee for deposit.
  - ii. If the donation is in another form, i.e. property, stocks, bonds, the recipient will inform the CFO who will take steps to secure and receive the donation. See Appendix B.
  - iii. The Accounting staff notifies the Executive Administrator of each donation, and the Executive Administrator will send an acknowledgement of appreciation to the donor.

- iv. The donation is deposited in the grant code that is specific to the donor's purpose/intent.
- v. If the donor's intent/purpose is nonspecific, the donation will be deposited in the grant code HLMISC Miscellaneous Gift Fund for the general benefit and comfort of the residents/patients.
- vi. Donations exceeding \$~~102525~~,000 require Health Commission and ~~the~~ Board of Supervisors' approval.
- vii. Names of individuals or organizations/groups making donations of \$100 or more to the Gift Fund of \$100 or more are posted on the Laguna Honda LHH website on a quarterly basis in accordance with the San Francisco Administrative Code (Section 67.29-6 Sunshine Ordinance).

## 2. Fund Oversight and Reporting:

- a. Grant Code Program Monitor.  
Each grant code will have an assigned Grant Code Program Monitor to assist in budget planning and supervising the budgeted expenses/expenditures for the assigned grant code(s).
- b. Gift Fund Management Committee.  
The Gift Fund Management Committee shall consist of the following: ~~Laguna Honda's Chief Financial Officer~~ LHH's CFO, Executive Administrator, Chief Nursing Officer, ~~Medical Director~~ Chief Medical Officer, Chief of Staff, Assistant Hospital Administrator for Clinical Services, Director of Wellness and Therapeutic Activities, Director of Social Services, President of Residents Council, and Ombudsman.—The Gift Fund Management Committee will meet at least quarterly to review and make recommendations for budget planning and expenditures.
- c. Executive Committee.  
The CFO, on behalf of the Gift Fund Management Committee, will provide quarterly reports of Gift Fund activities, i.e. donations and expenditures, to the Executive Committee. The Executive Committee provides additional and overall supervision of Gift Fund management.
- d. Health Commission.  
The CFO and Executive Administrator, through the Health Director, will provide ~~quarterly~~ updates as needed to the ~~Laguna Honda Joint Conference Committee~~ Health Commission of Gift Fund activities, including but not limited to donations, expenditures, ~~budget planning recommendations~~, and gift fund related policy and procedure revisions.

~~Laguna Honda~~LHH will work with the Department of Public Health to provide a report on an annual basis, in writing to the Health Commission and the Board of Supervisors a listing of all gifts, donations and contributions of money or personal property related to the Gift Fund.

- e. The City Controller's Office has the right to conduct final review and approval of all expenses.

### 3. Budgetary Planning:

- a. ~~Each fiscal year, no later than August–July 1, the CFO will provide to the Executive Administrator and the Gift Fund Management Committee Members the expenditure budget for the upcoming fiscal year. each of the grant codes specified in Appendix A so that activities and budgetary strategies can be established for the upcoming fiscal year. The CFO and Executive Administrator will then present the annual budget recommendations to the full Health Commission no later than August 1 of each year for approval.~~
- b. ~~AA~~ An out-of-budget funding request during the fiscal year shall be brought to the full Health Commission for approval before the expenditures can be made for any proposed expenditures from the Gift Fund not already included in the fiscal year budget approved by the Health Commission, or that do not fall under the miscellaneous category of the Gift Fund budget, an out-of-budget funding request during the fiscal year shall be brought to the full Health Commission for approval before the expenditures can be made.

### 4. Stock Management:

Each fiscal year, no later than August 1, the CFO will provide the Office of the Treasurer and Tax Collector (Treasurer's Office) the grant codes that contain donated stocks specified in Appendix B so that the department can actively manage the portfolio of stock bequests in the gift fund in accordance with the Treasurer's Office's investment policy. ~~Any~~ Any recommendations to change status of any stocks will be reviewed by the Gift Fund Management Committee prior to the Health Commission approval.

### 5. Interest

~~Interest generated from the all gift fund grant codes is distributed to the HLMISC grant code.~~

### 5.6. Expense Incurred:

- a. Before expenses are incurred, all expenses must be ~~pre-approved~~ reviewed and authorized by the ~~assigned Gift Fund Grant Code Program Monitor. Management Committee.~~ Purchases must be made consistent with City policies and

procedures for contracting and purchasing, i.e. purchases from City-approved vendors, encumbrances in place prior to ordering the item(s).— ~~Except for professional services (e.g. catering services), employees may purchase nominal (\$100) and singular items but pre-approval for the purchase must be obtained from the applicable Division Head.~~

- b. ~~All~~ Catering service requests must be additionally pre-approved by ~~the~~ CFO ~~and as well as~~ the Chief Operations ing Officer.

### 6-7. Reimbursement Process:

- a. ~~Except for professional services (e.g. catering services), employees may purchase nominal (up to \$200) and singular items, but pre-approval for the purchase must be obtained from the applicable Gift Fund Grant Code Program Monitor.—~~ The employee who incurs an expense shall follow the reimbursement policy to submit reimbursement requests to must (1) ~~complete and sign an Employee Reimbursement form, Appendix C;~~ (2) ~~secure the signature of the assigned Grant Code Program Monitor in advance of the expenditure consistent with the City process and the approved budget;~~ (3) ~~attach supporting original receipts and invoices;~~ and (4) ~~secure a second signature from the Gift Fund Monitor following the purchase;~~ (5) ~~forward the documents to the Laguna Honda~~ LHH Accounting Department.— Accounting staff will review documentation for appropriateness, validity, completeness and mathematical accuracy and will submit the documents to the CFO for approval.— Accounting staff will process approved requests through the City Controller's Office who provides final review and approval.— Estimated time for reimbursement to the employee is about seven days from the date approval is obtained from the Accounting Department.

### 7-8. Revolving Funds:

- a. ~~The Friends of Laguna Honda Laguna Honda Volunteers Inc.~~ routinely and regularly funds community outings, and household and neighborhood expenses, and hospital-wide programing for the purpose of resident activities for which a grant code, HLXPRF, has been established.
- b. Director of Wellness and Therapeutic Activities/designee will complete and submit a Gift Fund Revolving Fund Reimbursement form, Appendix DB, with original receipts to replenish the Revolving Fund on regularweekly basis.

#### ATTACHMENT:

~~Employee Expense Authorization and Reimbursement Form~~

Attachment A: Grant Codes for Cash Gifts for the General Benefit and Comfort of Residents/Patients

Attachment B: Gift Fund – Revolving Fund Reimbursement Form

Attachment C: Request for Gift Fund Funding Form

**REFERENCE:**

[LHHPP 50-06 Employee Reimbursement Request Guideline](#)

Materials Management Purchasing Policy

San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds)

[San Francisco Administrative Code \(Section 67.29-6 Sunshine Ordinance\)](#)

Revised: 98/11/16, 00/05/25, 04/12/02, 10/04/15, 11/01/25, 16/11/08 (Year/Month/Day)

Original adoption: 93/09/01

**Attachment A:**

## Grant Codes for Cash Gifts for the General Benefit and Comfort of Residents/Patients

<b>Grant Code</b>	<b>Description (in FAMIS)</b>	<b>Program Monitor</b>	<b>Purpose/Intent</b>
HLACTH	Activity Therapy	Director of <a href="#">Wellness and Therapeutic Activities</a>	Activity Therapy program related expenses
HLADDY	LHH Adult Day Health Center	Executive Administrator	Adult Day Health Center program related expenses, e.g. special food and beverages, flowers and sundries for participants
HLAIDF	LHH Aids Fund	Nursing Director for Positive Care program	Positive Care program related expenses, e.g. special food and beverages, flowers and sundries for residents
HLASIA	LHH Asian Focus	Nursing Director for Chinese language focus program	Chinese language focus program related expenses, e.g. special food and beverages, Chinese newspaper, flowers and sundries for residents
HLDTIA	LHH Dementia Program	Nursing Director for Memory Care program	Memory Care (Dementia) program related expenses, e.g. special food and beverages, flowers and sundries for residents
<a href="#">HLGSHP</a>	<a href="#">Gift Shop Sales and Donated Items</a>	<a href="#">Director of Wellness and Therapeutic Activities</a>	<a href="#">Resident related expenses e.g. special events, Special food and beverages, flowers and sundries for residents.</a>
<a href="#">HLKNGT</a>	<a href="#">Dolores Knight Bequest</a>	<a href="#">Director of Wellness and Therapeutic Activities</a>	<a href="#">Resident related expenses and activities, e.g. musical entertainment, cultural celebrations, holiday meals, and outings to ballgames, concerts, and other civic events.</a>
HLHSPC	<a href="#">Hospice Palliative Care</a>	Nursing Director for <a href="#">Palliative Care Hospice</a> program	Hospice program related materials and supplies, e.g. special food and beverages, flowers and sundries for residents

<b>Grant Code</b>	<b>Description (in FAMIS)</b>	<b>Program Monitor</b>	<b>Purpose/Intent</b>
<a href="#">HLMGFT S4</a>	<a href="#">Douglas Pinto</a>	<a href="#">Director of Wellness and Therapeutic Activities</a>	<a href="#">South 4 resident related expenses, e.g. special events, special food and beverages, flowers and sundries for residents.</a>
HLMGFT SA	Substance Abuse Treatment and Recovery Srvc Program	Chief of Psychiatry	STARTS program related expenses, e.g. special food and beverages, flowers and sundries for residents
<a href="#">HLGFT SC</a>	<a href="#">Spiritual Care Program</a>	<a href="#">Director of Social Services</a>	<a href="#">To benefit Spiritual Care programs</a>
HLMHBQ	Martin Heller Bequest	Director of <a href="#">Wellness and Therapeutic Activities</a>	Resident related expenses, e.g. special food and beverages, flowers and sundries for residents
<a href="#">HLNEIL</a>	<a href="#">Robert F. Neil</a>	<a href="#">Director of Wellness and Therapeutic Activities</a>	<a href="#">Donations in the name of our patient Robert F. Neil at CE3.</a>
<a href="#">HLSFWY</a>	<a href="#">Safeway Nutrition Program</a>	<a href="#">Chief Dietitian</a>	<a href="#">1. Senior Cooking with Kids 2. Cultural Nutrition Program</a>
HLTBIG	Traumatic Brain Injury Group	Chief of Psychiatry	Traumatic Brain Injury Group related expenses, e.g. special food and beverages
HLXPRF	LHH Express Fund	Director of <a href="#">Wellness and Therapeutic Activities</a>	Bus trips for residents, evening and weekend outings (majority funded by <a href="#">Friends of Laguna Honda Volunteers Inc.</a> )
<a href="#">HLROLS</a>	<a href="#">Milka Rols</a>	<a href="#">Nursing Director for Palliative Care program</a>	<a href="#">To benefit end-of-life programs hospital-wide</a>
<a href="#">HLTECH</a>	<a href="#">Molly's Fund</a>	<a href="#">Manager of Rehabilitation program Rehabilitation Coordinator</a>	<a href="#">To purchase assistive technology services and equipment for residents</a>
HLMISC	Miscellaneous Gift Fund	Director of <a href="#">Wellness and Therapeutic Activities</a>	Resident related expenses, e.g. special events, special food and beverages, flowers and sundries for residents

**Appendix B**

~~Grant codes with proceeds from donated stock.~~

<b>Grant Code</b>	<b>Description (in FAMIS)</b>	<b>Program Monitor</b>	<b>Purpose/Intent</b>
<del>HLENA</del>	<del>William Lenahan</del>	<del>Chief Financial Officer</del>	<del>Proceeds from <u>D</u>donated stocks and earned interests/dividends</del>
<del>HLMLWS</del>	<del>Marie Lewis</del>	<del>Chief Financial Officer</del>	<del>Proceeds from <u>D</u>donated stocks and earned interests/dividends</del>
<del>HLMISC</del>	<del>Miscellaneous Gift Fund</del>	<del>Chief Financial Officer</del>	<del>Proceeds from <u>D</u>donated stocks and earned interests/dividends</del>



**Appendix C**

Employee Reimbursement form:

**Attachment DB**

**Gift Fund – Revolving Fund Reimbursement Form**

**LAGUNA HONDA HOSPITAL  
CITY AND COUNTY OF SAN FRANCISCO  
GIFT FUND – REVOLVING FUND REIMBURSEMENT**

To: Accounting Department **Date:** \_\_\_\_\_

From: \_\_\_\_\_ **Telephone No.** \_\_\_\_\_

Print Name

**Fund:** 5L TAF ETF **Index Code:** HLH450221 **Grant/Detail:** \_\_\_\_\_

**Sub Object:** 04699 \$ \_\_\_\_\_ 04961 \$ \_\_\_\_\_ 04999 \$ \_\_\_\_\_  
Food Recreation supplies Other materials & supplies

03571 \$ \_\_\_\_\_ 02703 \$ \_\_\_\_\_ 03599 \$ \_\_\_\_\_  
Subscriptions Transportation services Other current expenses

**Total Requested Amount:** \$ \_\_\_\_\_ **Date(s) of expense:** \_\_\_\_\_

**Reason for Expenditure:**

- Social Services Petty Cash     STARS     Community Outings
- Community Reintegration     Hospital-Wide Programs     Neighborhood Money

**Patient's Name (if applicable):**

- 1. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_
- 2. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_
- 3. \_\_\_\_\_ 7. \_\_\_\_\_ 10. \_\_\_\_\_

**Staff and/or Volunteer's Name (if applicable):**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**Requested by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Employee: Print Name Signature

**Pre-approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Program Monitor/Division Head: Print Name Signature  
(or)

**Pre-approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Mivic Hirose, CEO or authorized designee

**Approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
ChiaYu Ma, CFO or authorized designee

**Note: Original receipts/invoices must be attached when submitting to Accounting.**

Revised: September 29, 2016

**Attachment C:**

**Request for Gift Fund Funding Form**

**Laguna Honda Hospital and Rehabilitation Center  
Request for Gift Fund Funding Form**

- For unbudgeted expenditures, not previously approved by the Gift Fund Committee and JCC
- The spending proposal must be for the benefit and wellbeing of Laguna Honda's residents/patients.
- Gift Fund Management Committee and JCC meets every other month. Please submit your request early for timely approval.

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

Request Submitted by: \_\_\_\_\_ Phone #: \_\_\_\_\_ Department: \_\_\_\_\_

Resident Name(s) (if applicable) \_\_\_\_\_ Trust Account Balance: \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

Program or Neighborhood \_\_\_\_\_ Program Monitor: \_\_\_\_\_

**Description of Spending Request:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How does this benefit the resident(s)?**

\_\_\_\_\_

Is this one-time request? Yes \_\_\_\_\_ No (please explain) \_\_\_\_\_

Total Amount Requested: \$ \_\_\_\_\_ - (including shipping, tax, and all fees)

-----  
(For Official Use Only)

Grant Code and Description: \_\_\_\_\_ Grant Code Balance: \_\_\_\_\_

Approved by: \_\_\_\_\_ on Committee Meeting Date: \_\_\_\_\_  
Gift Fund Management Committee

\_\_\_\_\_  
Committee Members present and voted

Approved by: \_\_\_\_\_ on JCC Meeting Date: \_\_\_\_\_  
Laguna Honda JCC

cc: Barbara Garcia, Director of Health

## **PAYOR ELIGIBILITY, CERTIFICATION AND COVERAGE**

### **POLICY:**

Utilization Management (UM) Nurse shall conduct admission/readmission review for Ppatients/residents who are admitted to the Acute Care—Medical Unit, Acute Rehab Unit, or a SNF Unit ~~willshall be reviewed for Medicare Part A eligibility~~ based on primary payor sources.

### **PURPOSE:**

Admission/readmission willshall be conducted by the UM Nurse following the criteria set by the primary payor sources. Patients/residents who meet the eligibility requirements of Medicare Part A care ~~will~~shall be covered under Medicare Part A benefits.

### **PROCEDURE:**

#### **1. Provision of Medicare Rights Form**

- a. All Medicare recipients upon admission or re-admission to SNF or Acute Rehab or Acute Medical must sign the Medicare Rights form. The financial counselor ~~will~~shall meet with the patient/resident and review the Medicare Rights form and secure a signature from the patient/resident or responsible party. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient/resident from SNF or Acute Rehab or Acute Medical discharges before a copy can be given, a copy ~~will~~shall be mailed to patient/resident.

#### **2. ~~Eligibility—Determination~~ of Primary Payor, Level of Care, Certification and Coverage**

- a. If the patient's/resident's face sheet indicates that the patient/resident has Medicare Part A ~~coverage~~, go to Procedure A.
  - i. If the patient's/resident's face sheet indicates Medi-Cal fee-for-service (FFS), go to Procedure B.
  - ii. If the patient's/resident's face sheet indicates SFHP-CHN, go to Procedure C.
  - iii. If the patient's/resident's face sheet indicates SFHP-UCSF, go to Procedure D.
  - iv. If the patient's/resident's face sheet indicates Anthem Blue Cross Medi-Cal Managed Care, go to Procedure E.
  - v. For other payor sources, go to Procedure F.

b. UM Nurse completes Utilization Review (UR) Daily Analysis form to identify sequence of payor sources (refer to Appendix L8).

### 3. Procedure A – Medicare Part A Coverage

- a. ~~The UM Nurse~~ utilization Management (UM) Coordinator confirms from the Medicare contracted vendor that the patient/resident:
- i. has Part A Medicare eligibility,
  - ii. is not currently enrolled in a Medicare Advantage Plan, or HMO Plan, and ~~HMO Plan, Managed care or private insurance~~
  - iii. has not exhausted his/her Medicare Acute Care or SNF benefits.

### ~~3. Level of Care Determination, Certification and Coverage~~

#### ~~a-b.~~ Acute Medical Care

- i. The Acute Care Admitting Physician signs the Acute Care Unit Physician Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record. Subsequent signatures may be made by the attending/covering physician for continued certification according to the required time frames. Completed Certification form ~~will~~shall be filed in the closed medical record under “Other Tab”
- ii. The UM Nurse enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4). The UM ~~Nurse~~Coordinator reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria. ~~Medical Acute Unit Admission Criteria for acute care coverage under Medicare Part A benefits~~
- iii. If the patient's stay does not meet the InterQual Adult Acute Level of Care cCriteria for admission, criteria for Medicare Part A ~~acute care coverage~~, the UM ~~Nurse~~ will~~shall~~ refer the case to the UM Nurse Manager for secondary review. The UM Nurse Manager will~~shall~~ either approve or ~~will~~shall ask UM Nurse to ~~Coordinator~~ speak with the attending Physician. If the Attending Physician concurs, the UM Nurse issues the Preadmission or ~~Admission~~ Hospital-Issued Notice of Noncoverage (refer to Appendix A2). If the attending Physician does not agree, the UM Nurse Manager will~~shall~~ refer the case to the UM Committee Chair or Physician Advisor.
- iv. If the patient's stay meets criteria ~~for Medicare Part A acute care coverage~~, the UM ~~Nurse~~ Coordinator ~~will~~shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay ~~and Discharge~~) in the using InterQual Adult Acute Level of Care Criteria via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR-
  - Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet ~~Medical Acute Unit Admission Criteria~~ the criteria for continued stay.
- v. When the patient no longer meets InterQual Adult Acute Level of Care criteria and there is no discharge plan, the UM Nurse ~~will~~shall refer the case to the UM Nurse Manager. The UM Nurse Manager ~~will~~shall either approved the case or ~~will~~shall ask the UM Nurse to speak with the attending physician to determine discharge plan.
- vi. When there is no discharge plan, the UM Nurse Manager ~~will~~shall refer the case to the UM Committee Chair or Physician advisor. If the UM Chair or Physician advisor concurs, the UM Nurse ~~will~~shall issue the Hospital-Issued Notice of Noncoverage Noncovered Continued Stay (refer to Appendix A3).

#### c. Acute Rehab

- i. The UM Nurse sends a notification via email on the day of admission or as soon as possible and after patient discharge to RAI, A & E, Billing, Pharmacy, Rehabilitation, PM Acute Rehab Team, MSW, staff responsible for completing Hudman Bed Call list, and other staff involved to complete the Patient Assessment Instrument (PAI).

The Charge Nurse (CN)/designee completes the PAI with input from other staff and notifies RAI Specialist/designee when PAI is ready for transmission. RAI Specialist or designee notifies UM, Billing, CN/NM/designee when PAI was transmitted. Status of PAI is reviewed during Triple Check meeting.

- ii. The UM Nurse enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5). The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.
- iii. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurse, and Physiatrists.
- iv. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or

attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse ~~will~~shall speak with the attending Physician to determine discharge plans.

d. SNF

- i. The UM Nurse ~~will~~shall ensure completion of Pre-Admission Screening Resident Review (PASRR). Refer to File 55-03 PASRR Policy.
- ii. The UM ~~Nurse~~Coordinator reviews the resident's medical record and determines if the resident's care meets the criteria for coverage under Medicare Part A SNF benefits.
- iii. If the resident's stay does not meet criteria for Medicare Part A SNF coverage, the UM ~~Nurse~~Coordinator issues the appropriate Medicare Denial letter (refer to Appendix M1 - M2).
- iv. If the resident's stay meets criteria for Medicare Part A SNF coverage, the UM ~~Nurse~~Coordinator ~~will~~shall conduct the following procedures
  - Completes and submits the SNF Physician Certification to the admitting physician for his/her signature of initial certification. Subsequent signatures ~~will~~shall be submitted to the attending/covering physician for continued certification according to the required time frames (see Appendix M3). When Medicare coverage is discontinued, the completed Certification form ~~will~~shall be filed in the medical record under "Other Tab". If the form was signed after the due date, the Delayed Physician Medicare Certification needs to be filled out/completed by the Physician (see Appendix M8).
  - Notifies the appropriate administrative and clinical team members that the resident's stay ~~will~~shall be covered under Medicare Part A SNF benefits. The administrative team consists of a designee from Admissions and Eligibility, pharmacy and staff responsible for entering Hudman Calls. The clinical team consists of the RAI Coordinator, Unit Nurse Manager, Physician and designated members of the Rehabilitation Department. Medicare sticker ~~will~~shall be placed on the spine of the chart on the front cover to alert staff regarding Medicare coverage and what the focus of documentation should address. During Medicare coverage, Licensed staff are to have at least daily nurses' notes to document the focus of skilled nursing care.
  - Conducts and documents periodic reviews to determine that the resident continues to meet Medicare Part A SNF coverage and benefits. Reviews ~~will~~shall be conducted on a weekly basis and no more than ten days shall lapse between reviews.

- Documents all pertinent reviews on the Medicare Information Summary (refer to Appendix M5). The reviews will~~shall~~ document the resident's qualifying stay, diagnosis, qualifying criteria for Medicare coverage and MDS Prospective Payment System (PPS) RUG scores according to the required schedule.
  - Maintains a monthly log of all residents covered on Medicare Part A SNF coverage (refer to Appendix M6).
- ~~v. Documents all pertinent reviews on the Medicare Information Summary (refer to Appendix M5). The reviews will document the resident's qualifying stay, diagnosis, qualifying criteria for Medicare coverage and MDS Prospective Payment System RUG scores according to the required schedule.~~
- ~~vi. Maintains a monthly log of all residents covered on Medicare Part A SNF coverage (refer to Appendix M6).~~
- vii-v. Completion of the Minimum Data Set (this is applicable only for SNF stays)
- The MDS is a clinical assessment tool that is completed by the resident care team and is the basis for the RUG IV Classification System. The MDS is completed according to the specified required intervals established by the Medicare PPS. Unless modified by the MDS Coordinators, ~~UM Coordinators~~ Nurses or member(s) of the resident care team, the MDS ~~will~~ shall be completed with Assessment Reference Dates (ARD) of Days 5, 14, 29, 59, and 89 while the resident is covered on Medicare Part A benefits. Other Medicare Required Assessments (OMRA) such as End of Therapy and Change of Therapy ~~will~~ shall be completed if indicated for ~~a~~ resident who is receiving rehabilitation therapy.

viii-vi. Medicare Denial Determination

~~b.~~ Acute Care

- ~~i. When the patient no longer meets criteria for acute level of care, the UM coordinator will~~ shall  ~~speak with the attending physician to determine discharge plans.~~
- ~~ii. When discharge is not planned, the UM Coordinator will~~ shall  ~~refer the case to the UM Committee Chair or Physician advisor. If the UM Chair or physician advisor concurs, issue the Hospital-Issued Notice of Noncoverage Noncovered Continued Stay (refer to Appendix A3).~~

~~c.~~ SNF



- When the resident no longer meets Medicare criteria for coverage under Part A benefits; the UM ~~Coordinator~~ Nurse, as the designated Administrative Officer ~~will~~ shall issue the appropriate Notice of Medicare Provider Non-Coverage letter, also known as the Generic Notice, no later than 2 days before covered services ~~will~~ shall end. The UM ~~Coordinator~~ Nurse ~~will~~ shall notify all appropriate administrative and clinical team members of the resident's non-coverage determination. The UM ~~Coordinator~~ Nurse must also provide a Detailed Explanation of Skilled Nursing Non-Coverage letter, also known as the Detailed Notice, to the resident or the responsible party, if the resident or responsible party chooses to appeal the Medicare denial determination with the Quality Improvement Organization (QIO). If the patient ~~will~~ shall remain in the SNF after Medicare coverage, the SNF Determination on Continued Stay ~~will~~ shall be issued by the UM ~~Coordinator~~ Nurse (refer to Appendix M4A, M4B and M4C for ~~the Generic~~, Detailed Notice, and SNF Determination on Continued Stay). The Admitting Manager ~~will~~ shall sign as verification of the receipt of the Generic notice. If a patient has no Medi-Cal Eligibility, the UM ~~Coordinator~~ Nurse obtains the patient's/resident's or responsible party's signature.
- vii. If the resident is not discharged from the skilled nursing facility and the resident or responsible party disagrees with the Medicare denial determination, the resident or responsible party can request for an intermediary review. The UM ~~Coordinator~~ Nurse ~~will~~ shall notify the Billing department regarding the beneficiary's request for a Demand Bill on a monthly basis.
- viii. The MDS Coordinators ~~clinical team~~ ~~will~~ shall also be notified regarding the Demand Bill and ~~will~~ shall be asked to complete a Demand Bill MDS.
- ix. The Utilization Management department ~~will~~ shall be notified by the Billing department regarding the outcome of the Intermediary's decision. Any decisions made by the Intermediary that is contrary to the facility's Medicare coverage determination ~~will~~ shall be reported and reviewed at the monthly Utilization Management Committee.
- x. Medicare Reinstatement (applicable only for SNF stays)
  - When a resident who has been issued a Medicare Denial letter experiences a change in condition that requires daily skilled services, and is within 30 days of the last Medicare covered day, s/he may be reinstated Medicare Part A benefits if s/he meets Medicare coverage criteria. The UM Nurse ~~Coordinator~~ ~~will~~ shall complete the Skilled Nursing Facility Reinstatement letter (see Appendix M7) to reinstate the resident's Medicare coverage and notify the appropriate administrative and clinical team members, resident care team and the Billing department of the change in coverage.

#### 4. Procedure B - Medi-Cal Fee for Service

##### a. Acute Medical

- i. The Acute Care Admitting Physician signs the Acute Care Unit Physician Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record. Subsequent signatures may be made by the attending/covering physician for continued certification according to the required time frames. Completed Certification form ~~will~~shall be filed in the closed medical record under "Other Tab"
- ii. The UM Nurse enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4). The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria. ~~Medical Acute Unit Admission Criteria for acute care coverage under Medicare Part A benefits~~
- iii. If the patient's stay does not meet the InterQual Adult Acute Level of Care Criteria, ~~criteria for Medicare Part A acute care coverage~~, the UM ~~Coordinator~~ Nurse ~~will~~shall refer the case to the UM Nurse Manager for secondary review. The UM Nurse Manager ~~will~~shall either approve the case or ask the UM Nurse to speak with the attending Physician. If the attending Physician does not agree, the UM Nurse Manager ~~will~~shall refer the case to the UM Committee Chair or Physician Advisor.
- iv. If the patient's stay meets ~~criteria for Medicare Part A acute care coverage~~, the UM Nurse ~~Coordinator~~ ~~will~~shall conduct the following procedures:
  - Enter acute care reviews (Admission, Continued Stay ~~and Discharge~~) in using InterQual Adult Acute Level of Care Criteria via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR.
  - Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.
- ii-v. When the patient no longer meets InterQual Adult Acute Level of Care criteria and there is no discharge plan, the UM Nurse ~~will~~shall refer the case to the UM Nurse Manager. The UM Nurse Manager ~~will~~shall either approved the case or ~~will~~shall ask the UM Nurse to speak with the attending physician to determine discharge plan.

vi. When there is no discharge plan, the UM Nurse Manager ~~will~~shall refer the case to the UM Committee Chair or Physician advisor.

b. Acute Rehab

v.i. The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.

ii. The UM Nurse enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5). The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, and Physiatrists.

iii. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse ~~will~~shall speak with the attending Physician to determine discharge plans.

iv. If the patient is going to be discharged to a SNF and there is no available SNF bed the attending Physician ~~will~~shall document in the progress notes that the patient is awaiting for SNF bed availability. The UM Nurse ~~will~~shall request to staff responsible for entering Hudman Bed Call list to start the calls.

c. SNF

i. The UM Nurse reviews the resident's medical record and determines the resident's care needs and the reason for admission.

ii. The UM Nurse enters/updates the Medi-Cal SNF Log (refer to Appendix 9)

iii. The UM Nurse ensures the completion of ~~PreAdmission Screening Resident Review (PASRR)~~. Refer to File: 55-03 PASRR Policy.

iv. The UM Nurse ensures the completion of Treatment Authorization Request (TAR). Refer to File: 55-02 Processing of Long Term Care Treatment Authorization Requests Policy.

**5. Procedure C - SFHP CHN Coverage**

a. Acute Medical

- i. The UM Nurse obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to verify patient's membership with SFHP.
- ii. The UM Nurse notifies SFHP via telephone of patient's admission. The UM Nurse enters the patient information in the log of PMA Admission and SFHP Patient List and update as needed (refer to Appendix L4 and L2).
- iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.
- iv. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses ~~Coordinators~~ notifying them of patient's coverage under SFHP-CHN.
- v. The Acute Care Admitting Physician signs the Acute Care Unit Physician Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record. Subsequent signatures may be made by the attending/covering physician for continued certification according to the required time frames. Completed Certification form ~~will~~shall be filed in the closed medical record under "Other Tab"
- vi. The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria for admission. ~~Medical Acute Unit Admission Criteria for acute care coverage under Medicare Part A benefits~~
- vii. If the patient's stay does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse ~~will~~shall refer the case to the UM Nurse Manager for secondary review. The UM Nurse Manager ~~will~~shall either approve the case or ask the UM Nurse to speak with the attending Physician. If the attending Physician does not agree, the UM Nurse Manager ~~will~~shall refer the case to the UM Committee Chair or Physician Advisor.
- viii. If the patient's stay meets criteria ~~for Medicare Part A acute care coverage~~, the UM Nurse ~~Coordinator~~ ~~will~~shall conduct the following procedures:
  - Enter acute care reviews (Admission, Continued Stay ~~and Discharge~~) using InterQual Adult Acute Level of Care Criteria via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR.
  - Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

- ix. When the patient no longer meets InterQual Adult Acute Level of Care criteria and there is no discharge plan, the UM Nurse ~~will~~shall refer the case to the UM Nurse Manager. The UM Nurse Manager ~~will~~shall either approved the case or ~~will~~shall ask the UM Nurse to speak with the attending physician to determine discharge plan.
- x. When there is no discharge plan, the UM Nurse Manager ~~will~~shall refer the case to the UM Committee Chair or Physician advisor.

#### b. Acute Rehab

- i. The UM Nurse obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to verify patient's membership with SFHP.
- ii. The UM Nurse affixes a sticker (neon) on the spine of the chart for ~~to~~ RCT to identify that the patient has private insurance.
- iii. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.
- iv. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2). The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.
- v. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, Physiatrists.
- vi. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse ~~will~~shall speak with the attending Physician to determine discharge plans.
- vii. If the patient is going to be discharged to a SNF and there is no available SNF bed, the attending Physician ~~will~~shall document in the progress notes that the patient is awaiting for SNF bed availability. The UM NurseCoordinator ~~will~~shall request to staff responsible to entering Hudman Bed Call list to start the calls.

#### c. SNF

- i. The UM Nurse ensures the completion of ~~PreAdmission Screening Resident Review~~ (PASRR). Refer to File: 55-03 PASRR Policy.
- ii. The UM Nurse obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to verify patient's membership with SFHP.
- iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for the RCT to identify that the patient has a private insurance.
- iv. The UM Nurse sends a notification via email on the day of admission or soon ~~thereafter~~ thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.
- v. The UM Nurse enters the patient information in the SFHP List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical record for skilled nursing/rehab needs.
- vi. The UM Nurse obtains information from review of medical record or from RCT re discharge plan. Communicates with A & E as needed.
- vii. The UM Nurse sends to SFHP on the 1<sup>st</sup> working day of the month via fax the list of patients who are due for disenrollment which includes patient name, admit date, discharge location/date, SFHP ID, date of service, term date (refer to Appendix L1). Facesheets are also sent.
- viii. UM Nurse/designee sends monthly list of SFHP-CHN patients to Billing Department, A & E, Rehab, RAI, Pharmacy, Staff responsible for entering Hudman Bed Call list every 1<sup>st</sup> week of the month which includes patient name, unit, admit date, SFHP ID, date of service, discharge location/date, term date (refer to Appendix L2).

## 6. Procedure D – SFHP-UCSF Coverage

### a. Acute Rehab

- i. The UM Nurse ensures that pre-authorization is received from A & E.
- ii. The UM Nurse obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to verify patient's membership with SFHP.
- iii. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.

- iv. The UM Nurse affixes a sticker (neon) on the spine of the chart for ~~to~~ RCT to identify that the patient has private insurance.
- v. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses ~~Coordinators~~ notifying them of patient's coverage under SFHP-UCSF.
- vi. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2). The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.
- vii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicate with A & E as needed.
- viii. The UM Nurse sends copies of medical records to SFHP-UCSF weekly via fax to obtain authorization for continued stay.
- ix. The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses ~~Coordinators~~, Physiatrists.
- x. When the patient no longer meets the required acute inpatient intensive rehabilitation therapy minutes, the UM Nurse ~~will~~ shall speak with the attending Physician to determine discharge plans if there are no documented discharge plan.
- xi. If the patient is still meeting the acute inpatient intensive rehabilitation therapy and denial received from SFHP-UCSF, the UM Nurse ~~will~~ shall discuss case with SFHP-UCSF. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.
- xii. Sends a notification via email to A& E, Billing, ~~Staff and Staff~~ responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF.
- xiii. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF.

b. SNF

- i. The UM Nurse ~~will~~shall ensure the completion of PASRR. Refer to ~~File~~LHPP 55-03 PASRR Policy.
- ii. The UM Nurse ~~will~~shall ensure that pre-authorization is received from A & E.
- iii. The UM Nurse obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to verify patient's membership with SFHP
- iv. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.
- ~~ii.v.~~ The UM Nurse affixes a sticker (neon) on the spine of the chart for ~~to~~-RCT to identify that the patient has private insurance.
- vi. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses ~~Coordinators~~ notifying them of patient's coverage under SFHP-UCSF.
- vii. The UM Nurse enters the patient information in the SFHP Patient List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical records and progress notes for determination of skilled needs.
- viii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.
- ix. The UM Nurse sends copies of medical records ~~weekly~~ to SFHP-UCSF via fax to obtain authorization for continued stay.
- x. If denial for continued stay received from SFHP-UCSF, the UM Nurse ~~will~~shall discuss case with SFHP-UCSF. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.
- xi. Sends a notification via email to A& E, Billing, ~~Staff and Staff~~ responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF.
- xii. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF.

## 7. Procedure E – Anthem Blue Cross Medi-Cal Managed Care Coverage

### a. Acute Rehab



- i. The UM Nurse ensures that pre-authorization is received from A & E.
- ii. The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.
- iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for ~~to~~-RCT to identify that the patient has private insurance.
- iv. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses ~~Coordinators~~ notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care.
- v. The UM Nurse enters the patient information in the Log of PMR Admission and Anthem Blue Cross Medi-Cal Managed Care Patient List (refer to Appendix L5 and Appendix L6). The UM Nurse reviews the medical records and progress notes from the therapists and determine if patient is ~~still~~-meeting the required therapy minutes for acute inpatient intensive rehabilitation.
- vi. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicate with A & E as needed.
- vii. The UM Nurse sends copies of medical records to Anthem Blue Cross UM RN weekly via fax to obtain authorization for continued stay. When approved the UM Nurse ~~will~~shall receive the authorization for continued stay via fax.
- viii. The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Coordinators, Physiatrists.
- ix. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons and/or there is no discharge plan, the UM Nurse ~~will~~shall speak with the attending Physician to determine discharge plans.
- x. If the patient is still meeting the acute inpatient intensive rehabilitation therapy and denial received from Anthem, the UM Nurse ~~will~~shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next step as recommended by Anthem Blue Cross such as peer-to-peer review within 30 days of receiving the denial or appeal the denial.

- xi. The UM Nurse sends a notification via email to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurse notifying them of patient's coverage under Anthem Blue Cross.
- xii. When the patient is discharged either to the acute hospital or to the community, the UM Nurse notifies Anthem Blue Cross to obtain authorization for bedhold if discharge is to the acute hospital.

b. SNF

- i. The UM Nurse ~~will~~shall ensure that pre-authorization is received from A & E.
- i.ii. The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.
- iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for to RCT to identify that the patient has private insurance.
- iv. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care.
- v. The UM Nurse enters the patient information in the Anthem Blue Cross Medi-Cal Managed Care Patient List and updates as needed (refer to Appendix L6). -The UM Nurse reviews the medical records if patient meets the levels of care by Anthem Blue Cross.
- vi. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.
- vii. The UM Nurse sends copies of medical records to Anthem Blue Cross UM weekly via fax to obtain authorization for continued stay. When approved the UM Nurse ~~will~~shall receive the authorization for continued stay via fax. The UM Nurse ~~will~~shall make sure the approved level of care is appropriate. If not, the UM Nurse ~~will~~shall discuss this with Anthem Blue Cross UM RN.
- viii. If the patient is still meeting the levels of care by Anthem Blue Cross -and denial for continued stay was received, the UM Nurse ~~will~~shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next steps recommended by Anthem Blue Cross such peer-to-peer within 30 days of receiving the denial or appeal the denial according to required time frames.

- ix. The UM Nurse sends a notification via email to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross.
- x. The UM Nurse notifies Anthem Blue Cross about patient's disposition. When the patient is discharged to the Acute Hospital, UM Nurse obtains authorization for bedhold.

## **8. Procedure F – Other Payor Coverage**

- a. A & E sends Letter of Agreement (LOE) and any other information related to this case.
- b. The UM Nurse notifies payor/insurance of this admission on the day of admission or soon thereafter and obtain information from the payor of the requirements to obtain coverage for this admission.
- c. The UM Nurse enters patient information in the Other Payor List and updates as needed (refer to Appendix L7).
- d. For any issues, obtain assistance from OMC as necessary.

### **ATTACHMENT:**

Appendix A1: Acute Care Unit Physician Certification

Appendix A2: Preadmission or Admission Hospital-Issued Notice of Noncoverage

Appendix A3: HINN Noncovered Continued Stay

Appendix L1: SFHP Patient List (for SFHP)

Appendix L2: SFHP Patient List

Appendix L3: Acute Rehab Patient List

Appendix L4: Log of PMA Admission

Appendix L5: Log of PMR Admission

Appendix L6: Anthem Blue Cross Medi-Cal Managed Care

Appendix L7: Other Payor List

Appendix L8: Utilization Review Daily Analysis

Appendix L9: Medi-Cal SNF Log

Appendix M1: SNF Determination on Admission

Appendix M2: Notice of Exclusions from Medicare Benefits - SNF

Appendix M3: SNF Physician Certification

Appendix M4A: The Generic Notice (Notice of Medicare Provider Non-Coverage)

Appendix M4B: The Detailed Notice (Detailed Explanation of Non-Coverage)

Appendix M4C: SNF Determination on Continued Stay

Appendix M5: Medicare Information Summary

Appendix M6: ~~Monthly~~ Medicare Part A SNF ~~List~~Log

Appendix M7: Skilled Nursing Facility Reinstatement

Appendix M8: Delayed Physician Certification

**REFERENCE:**

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf>  
LHHPP 55-02 Processing of Long Term Care TARs  
LHHPP 55-03 PASRR

Revised: 04/08/19, 05/08/18, 08/04/17, 10/08/19, 11/09/27, 14/01/28, 14/03/25,  
14/07/29, 16/11/08 (Year/Month/Day)  
Original Adoption: Est. 1993

## PROCESSING OF LONG TERM CARE TREATMENT AUTHORIZATION REQUESTS

### POLICY:

1. The Utilization Management (UM) Department is responsible for submitting Long Term Care (LTC) ~~Electronic~~ Treatment Authorization Requests (~~e~~TARs) for all residents who are admitted to the facility and whose LTC stays are eligible for Medi-Cal reimbursement.
- ~~1.2.~~ Effective July 1, 2016, TARs shall be electronically submitted to the Medi-Cal office according to procedures established by the Department of Health Care Services (DHCS) eTAR Medi-Cal User Guide.

### PURPOSE:

LTC ~~e~~TARs shall be submitted via the Medi-Cal Website ~~to the designated Medi-Cal Field Office~~ so that the facility can receive the maximum allowable reimbursement dollars from Medi-Cal, in order to meet or exceed the annual fiscal budget for the facility.

### PROCEDURE:

#### 1. ~~eTAR~~ Submission

- ~~a. LTC eTARs shall be submitted via the Medi-Cal website to the designated Medi-Cal Field Office according to the requirements specified in the Department of Health Care Services (DHCS) eTAR Medical User Guide. Medi-Cal LTC Provider Manual.~~
  - a. The submission of Initial LTC TARs is based on the monthly log of Utilization Review Daily Analysis created by the TAR Clerk.
  - b. The submission of LTC Re-Authorization TARS is based on the monthly log of Re-Authorization TARs created by the TAR Clerk.

#### 2. ~~eTAR~~ Tracking

- a. The TAR Clerk is responsible for tracking the status of the submitted ~~e~~TARs via the [Medi-Cal website](#) at least once a week.
  - b. Refer to Procedures 3 through 7, for continued tracking procedures related to Modified, Deferred and Short Stay TARs, TARs approved for 2 years and Denied TARs, respectively.
- For deferred TARs, go to Procedure 3. For modified TARs, go to Procedure 4. For TARs approved for short stay, go to Procedure 5. For TARs approved for 2 years, go to Procedure 6. For denied TAR, go to Procedure 7.

### **2.3. eTAR Deferrals**

- a. The TAR Clerk enters the TAR information number in the Deferred TAR Log and provides copy to the UM Nurse.
- b. The UM Nurse shall responds to the deferred TAR within 30 days of the adjudication date via the Medi-Cal website with additional documentation, correction, and or clarification to the TAR information as requested by the Medi-Cal Field Office. After responding to the deferred TAR, the TAR Clerk updates the Deferred TAR log and shall go to tracks the TAR status; go to Procedure 2.
- c. If TAR is deferred because the Medi-Cal Consultant has determined that the resident is at lower level of care (LLOC), the UM Nurse notifies Unit Nurse Manager, attending Physician, Social Worker, UM Nurse Manager, Director of Social Services and Patient Flow Coordinator.

### **3.4. Modified TARs**

- a. The TAR Clerk enters the TAR information in the Modified TAR log and provides copy to the UM Nurse.
- b. The UM Nurse reviews the approved period of service (POS) and TAR comments and determines the next action.
- c. If the TAR is modified due to a LLOC determination, the UM Nurse notifies Unit Nurse Manager, attending Physician, Social Worker, UM Nurse Manager, Director of Social Services and Patient Flow Coordinator.
- d. The TAR Clerk prepares/updates the Re-Authorization TAR List and informs the UM Nurse of the updated list.
- e. The UM Nurse shall submit a new TAR with additional documentation, correction, and clarification to the TAR information as requested by the Medi-Cal Field Office.

### **5. Approved TARs for Short Stay**

- a. The TAR Clerk enters the TAR in the Modified TAR log and provides copy to the UM Nurse.
- b. If the TAR is approved for period of service of <2 years (either due to the requested period of service by the UM Nurse secondary to potential LLOC or due to approved period of service by Medi-Cal Field Office for potential LLOC), the process is the same as a modified TAR; go to Procedure 4.

### **6. TARs Approved for 2 Years**

- a. The TAR Clerk updates the monthly log of Utilization Review Daily Analysis. Logs and distributes the TAR copy for the UM Nurse to review, initials the TAR copy and return to the TAR Clerk.
- b. The TAR Clerk prepares/updates the Re-Authorization TAR List and informs the UM Nurse as needed of the updated list.

#### **4.7. TAR Denials**

- a. The TAR Clerk enters the TAR information in the denied TAR log and provides copy to the UM Nurse.

b. If the LTC TAR is denied for lack of Medi-Cal eligibility, no action shall be taken until the resident becomes Medi-Cal eligible for long-term care services. When the resident becomes Medi-Cal eligible, a new TAR shall be submitted via the Medi-Cal website ~~Field Office~~ for TAR approval according to the requirements specified in the Medi-Cal LTC Provider Manual.

a-c. If the LTC TAR is denied for failure to meet Nursing Facility-B (NF-B) Level of Care (LOC) requirements, the following actions shall be taken:

- i. The resident shall be issued with the Notice of Proposed Transfer/Discharge according to the facility protocol for issuing discharge notices. If the resident contests the discharge plan, a discharge hearing shall be convened to address the resident's concerns. The designated member of the Resident Care Team shall write a note in the progress notes indicating the resident's decision to contest the discharge notice.
- ii. A single level TAR appeal shall be submitted to the TAR Appeals, TAR Administrative Remedy Section by the Utilization Management designee within the required time frame (180 days from the TAR decision date) with available supporting documentation to demonstrate the resident's NF-B LOC needs.

b-d. If the LTC TAR is denied for failure to meet the requirement(s) specified in the Medi-Cal LTC Provider Manual the following action shall be taken:

- i. A single level appeal shall be submitted to the TAR Appeals, TAR Administrative Remedy Section by the Utilization Management designee within the required time frame (180 days from the TAR decision date), only when there is available supporting documentation that can be used to refute the basis of TAR denial, or satisfy the documentation requirements specified in the Medi-Cal LTC Provider Manual.

#### **5.8. LTC TAR Reporting and Performance Improvement**

- a. Medi-Cal LTC TARs that are denied for reasons other than the lack of patient eligibility; shall be reported to the Utilization Management Committee.
- b. To minimize future LTC TAR denials, the Utilization Management Nurse Manager shall ~~must~~ identify and recommend action plan(s) related to these LTC TAR denials and request that the action plan(s) be approved for implementation by the Utilization Management Committee.

**ATTACHMENT:**

None.

**REFERENCE:**

Department of Health Care Services (DHCS) TAR Medical User Guide  
LHHPP 20-04 Discharge Planning  
Section T Medi-Cal Long Term Care Provider Manual  
State Operating Manual F201 – F204

Revised: 10/08/19, 16/11/08 (Year/Month/Day)

Original adoption: 05/05/19



## PASRR

### POLICY:

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

### PURPOSE:

1. To screen and identify residents who may have a diagnosis of mental illness (MI) and/or mental retardation (MR), and to refer these residents to the Department of Mental Health (DMH), and/or Department of Developmental Services (DDS).
2. To partner and coordinate the assessment review process with State programs and ensure that individuals with mental illness and mental retardation receive the care and services they need in the most appropriate setting.

### BACKGROUND:

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

### PROCEDURE:

#### 1. Completion of PASRR

- a. Upon resident admission, the Utilization Management (UM) Nurse completes the revised PASRR Level ~~I~~ DHCS Form 6170 ~~via~~ ~~DHCS'~~ PASRR web-based system.
- b. The web-based system generates a "No Need Letter" if the resident does not need referral to DMH or DDS. ~~The system generates a "Need Letter" if the resident does need referral to DMH or DDS.~~

Note: If a PASRR Level I was recently submitted and is pending evaluation/determination or still an active case, the system is not going to allow another entry/submission of an Initial PASRR Level I (refer to Attachment A – duplicate entry message).

The UM Nurse sends via email the printout of the PASRR Level ~~I~~ and the ~~Notice of No Need Letter~~ or Need Letter to Health Information Services (HIS) and to Social Services (SS) ~~for filing in the medical record~~ and files ~~attaches~~ a copy to the

electronic Treatment Authorization Request (eTAR) folder. ~~and UM Department case files.~~ HIS uploads the PASRR Level I and the Letter in the electronic health record (EHR). Social Services shall give the Notice of No Need Letter or Need Letter to the resident/responsible party.

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

## 2. Completion of Level II referral to DMH

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

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

~~e.b.~~ \_\_\_\_\_ UM Designee logs the PASRR referral and files a copy.

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

~~e.d.~~ \_\_\_\_\_ The assigned psychologist or psychiatrist shawill contact the neighborhood staff or contact the UM Nurse Manager or designee who shawill inform the neighborhood nurse ~~before when~~ the psychologist/psychiatrist will come on-site to conduct the evaluation. The UM designee shall also inform the neighborhood Nurse Manager/Charge Nurse to put a printout of the medications in the front of the medical record.

## 3. Completion of Level II referral to DDS

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

~~a.~~ The UM Nurse sends the referral via fax to DDS.

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

~~e.b.~~ \_\_\_\_\_ The UM Nurse Manager or Designee shawill update PASRR – SFGetCare of the referral.

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

d. The Golden Gate Regional Center (GGRC) representative obtains patient information from UM Nurse Manager or designee prior to conducting Level II evaluation.

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

#### 4. Review by the Resident Care Team (RCT)

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

b. The UM Nurse completes status change PASRR Level 1 via DHCS' PASRR web based system. Go to procedure 1 for completion of PASRR. Go to procedure 2 for completion of Level II referral to DMH. Go to procedure 3 for completion of Level II referral to DDS.

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

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

The UM Nurse sends via email the printout of the PASRR Level 1 and the Notice of No Need Letter to Health Information Services (HIS) for filing in the medical record and files attaches a copy to the electronic Treatment Authorization Request (eTAR) folder. and UM Department case files. HIS uploads the PASRR Level 1 in eCW.

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

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

#### 5. DMH Report

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

i. Log the report

ii. File one copy in the UM DMH PASRR binder

Send one copy to County Mental Health via mail.

- b. The UM Nurse shall send the report via email to HIS to upload in eCWEHR. and, Social Services via email and to MD (routes to Psychiatry Services)
- i. ~~Send one copy to County Mental Health~~ Attach one copy to TAR. The UM Nurse files a copy to the eTAR folder. The UM Nurse shall send the report via email to SS and to County Mental Health. The MSW shall give the report to the resident/responsible party.  
~~File one copy in the UM DMH binder~~  
 Note: ~~The DH no longer completes 1-page Categorical or Attempted Letter. The UM Nurse attaches to the TAR a screen shot of the resolution from web-based system.~~ In April 2016, the DMH started completing a 1-page categorical letter.
- c. If the Level II Determination Letter is not available in the web based system in 14 days following evaluation, the UM Nurse Manager or designee shall follow-up and contact DMH.
- ~~b.d.~~ The Physician shall review the PASRR Report with the Resident Care Team (RCT) during IDT meetings.
- ~~e.e.~~ MSW shall also initiate Level II discussion with RCT ~~to review recommendations,~~ revises the plan of care and discharge plan as needed or otherwise addresses recommendations that are not implemented in the medical record.

## 6. DDS Report

- a. Upon receiving the GGRC report, the UM Nurse Manager or designee shall:
- i. Log GGRC report
  - ii. Upload scanned DDS report at PASRR – SFGetcare
  - iii. Update PASRR – SFGetcare
  - iv. Send report ~~to HIS~~ via email for filing in the medical records for uploading in eCWEHR, and to MD and Social Services via email and to the MD
  - v. Send report to SS.
  - vi. ~~Attach one copy to TAR.~~ File a copy in the eTAR folder.
  - vii. File one copy in the UM DDS binder
- b. The Physician shall review the Report with the Resident Care Team (RCT) during IDT meetings.

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

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

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

**ATTACHMENT:**

[Attachment A: Duplicate Entry Message](#) ~~None~~

**REFERENCE:**

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

Revised: 15/07/14, 16/08/18, 16/11/08 (Year/Month/Day);  
Original adoption: 11/11/29

Attachment A: Duplicate Entry Message

The screenshot displays the PASRR Level I Wizard interface. At the top, there is a navigation bar with 'Dashboard' and 'Level I' dropdown menus, and a 'Welcome, [User Name]' greeting. Below this, the breadcrumb path shows 'PASRR I > PASRR I Wizard'. The main area features a progress bar with six steps: 1. Resident Identification (completed), 2. Resident Information (current step), 3. Facility Completing Level I, 4. 30-Day Exempted Hospital Discharge, 5. Categorical Determination, and 6. MI Screen. The 'Resident Information' section contains several fields: 7. Gender (dropdown menu), 8. Marital Status (dropdown menu), 9. Primary Language Spoken (dropdown menu), and 11. Hearing Impaired? (radio buttons for Yes and No). An error message dialog box is overlaid on the form, stating: 'Error Message: This is a duplicate entry with the caseid : and which is an active case and a Level I is not required.' with an 'OK' button. At the bottom right, there are 'Prev' and 'Next' navigation buttons. The footer contains the copyright notice 'Copyright © 2016 State of California, All Rights Reserved.' and the version number 'PASRR Version 3.14.0.0'.

## BLOODBORNE PATHOGEN ~~OCCUPATIONAL~~ EXPOSURE CONTROL PLAN

### **PURPOSE:**

~~The intent of the Laguna Honda Hospital Bloodborne Pathogen Occupational Exposure Control Program (Laguna Honda BBPECP) to provide a working environment that minimizes or eliminates risk for an occupational exposure to transmissible bloodborne pathogens.~~

### **POLICY:**

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy workplace by minimizing employee exposures to bloodborne pathogens.

### **PURPOSE:**

1. To implement procedures for controlling exposure to bloodborne pathogens and for follow up of exposures that occur in the workplace.
2. To comply with the California Code of Regulations, Title 8, Section 5193 Bloodborne Pathogens and Section 3203 Injury/Illness Prevention.

### **SCOPE:**

- The Laguna Honda LHH Bloodborne Pathogen Exposure Control Program (BBP Plan) ECP applies to Laguna Honda LHH employees ~~and volunteers of~~ whom, as a result of the performance of their job duties, are reasonably expected to be occupationally exposed to human blood, body fluids, or other potentially infectious materials (OPIM). A list of job classes expected to be occupationally exposed is provided in Appendix A: Exposure Determination.
- Non-Laguna Honda LHH personnel, including but not limited to, ~~employees of the University of California San Francisco (UCSF)~~, contract employees, registry personnel, and professional or student affiliates shall:
  - ~~Be covered by their primary employer's plan for Receive bloodborne pathogen training, vaccines, exposure reporting, and post exposure follow-up from by~~ their primary employer.
  - ~~Comply with their own respective organization's existing personnel policies and procedures, relative to reporting and investigation of work-related injury and illness and employees' compensation benefits.~~

- b. Be provided with site-specific training and, personal protective equipment by Laguna Honda LHH, ~~and environmental controls by Laguna Honda Hospital and Rehabilitation Center (Laguna Honda)~~

## PROCEDURE:

### ~~1. Roles and Responsibilities:~~

~~i. Laguna Honda Executive Administrator or Designee shall:~~

- ~~i. Ensure the required resources and leadership are provided for the implementation of this program.~~
- ~~ii. Annually review and approve the Laguna Honda BBPECP.~~

~~ii. Laguna Honda Directors of Medicine, Nursing and Operations shall:~~

- ~~i. Ensure all components of the Laguna Honda BBPECP are implemented.~~
- ~~ii. Ensure that managers and supervisors follow procedures as outlined.~~
- ~~iii. Annually review and approve the Laguna Honda BBPECP and facilitate correction of deficiencies.~~

~~iii. Laguna Honda Managers and Supervisors shall:~~

- ~~i. Ensure employees comply with work practice controls.~~
- ~~ii. Evaluate compliance to the Laguna Honda BBPECP and policies and procedures.~~
- ~~iii. Document noncompliance, counsel, coach, train employees and take disciplinary action as indicated.~~
- ~~iv. Ensure the availability of personal protective equipment (PPE) and safety devices.~~
- ~~v. Ensure PPE and safety devices are used appropriately.~~
- ~~vi. Ensure that employees in their unit/department receive initial and retraining as indicated in Section VII Training of this document.~~
- ~~vii. Complete the forms listed below and submit to the Department of Public Health (DPH) Occupational Safety and Health Section in the event of an exposure.~~



- ~~• Employee's Claim for Worker's Compensation Benefits, Department of Worker's Compensation (DWC/Form-1)~~
- ~~• Employer's Report of Occupational Injury Illness (Form 5020/Form-2)~~
- ~~• Supervisor's Incident Investigation Report (SIIR)~~

~~iv. Laguna Honda Employee shall:~~

- ~~i. Be Responsible and accountable for compliance with the Laguna Honda BBPECP.~~
- ~~ii. Follow safe work practices and Body Substance Precautions (BSP).~~
- ~~iii. Accept or decline in writing the HBV vaccine; adhere to the recommended schedule for administration of the HBV vaccine and testing after completion of the series.~~
- ~~iv. Attend the required Laguna Honda BBP trainings as directed.~~
- ~~v. Attend unit specific training if applicable.~~
- ~~vi. Use only those devices for which they have received training.~~
- ~~vii. Report any occupational exposure or "near miss" to supervisor/manager.~~
- ~~viii. Call the Needlestick Hotline (469-4411) to report all exposures to blood and other body fluids.~~

~~v. Laguna Honda Infection Control Committee (LHH-ICC) shall:~~

- ~~i. Review bloodborne pathogen exposures from the Sharps Injury Log to evaluate the circumstances surrounding incidents.~~
- ~~ii. Recommend changes to work practices.~~
- ~~iii. Review and update the written Laguna Honda BBPECP annually as indicated in Section X Program Evaluation.~~
- ~~iv. Ensure the solicitation and documentation of input from non-managerial employees responsible for direct patient care for the purpose of updating work practices and the Laguna Honda BBPECP.~~
- ~~v. Provide consultation on infection control and bloodborne pathogen exposure control to clinical staff.~~

- ~~vi. Review and recommend improvements to Laguna Honda BBPECP training curricula.~~
- ~~vii. Participate in the DPH Safe Device s Committee.~~
- ~~vi. DPH Bloodborne Pathogen Safe Device Committee (DPH-BPSDC) shall:~~
  - ~~i. Review bloodborne pathogen exposures from the Sharps Injury Log to determine the frequency and circumstance of exposure and type of sharps involved.~~
  - ~~ii. Recommend changes to engineering controls.~~
  - ~~iii. Identify, evaluate, and select currently available engineering controls.~~
  - ~~iv. Ensure the solicitation of input from non-managerial employees responsible for direct patient care for the purpose of evaluating engineering controls.~~
  - ~~v. Review and recommend improvements to Laguna Honda BBPECP training curricula.~~
- ~~vii. San Francisco Department of Public Health Occupational Health Service Clinic (SFDPH-OHS Clinic) shall:~~
  - ~~i. Provide a confidential, comprehensive post-exposure management program that is available for employees incurring occupational bloodborne exposures.~~
  - ~~ii. Coordinate, implement, and document the Hepatitis B antibody testing and vaccination program.~~
  - ~~iii. Complete and maintain required health medical records.~~
  - ~~iv. Ensure that Doctor's First Report of Illness/Injury (DFR) is completed as appropriate; forward BBERF to the SF DPH Occupational Safety and Health SFDPH-OSH Section.~~
  - ~~v. Provide Needlestick Hotline services, including but not limited to:~~
    - ~~• Exposure evaluation.~~
    - ~~• Referral to Laguna Honda Pharmacy or San Francisco General Hospital Emergency Department (SFGH ED) as necessary.~~
    - ~~• Referral to SFDPH-OHS Clinic for follow up care.~~
    - ~~• Completion of Blood/Body Fluid Exposure Report Form (Appendix A).~~

- ~~• Notify Laguna Hospital physician designated by the Laguna Honda Medical Director to obtain source patient information.~~
  - ~~• Provide exposure data to SFDPH OSH Section for inclusion into Sharps Injury Log.~~
- viii. ~~Laguna Honda Designated Physician for Bloodborne Pathogen Exposure shall:~~
- ~~i. Perform source patient evaluation and testing.~~
  - ~~ii. Submit source patient results to SFDPH OHS Clinic.~~
- ix. ~~SFDPH Occupational Safety and Health Section (SFDPH OSH Section) shall:~~
- ~~i. Develop and maintain the Sharps Injury Log for Laguna Honda as specified in California Code of Regulations, Title 8, Section 5193 (c)(2)(A-E).~~
  - ~~ii. Provide Sharps Injury Log data to the DPH-BPSDC and LHH-ICC for review.~~
  - ~~iii. Coordinate pilot evaluations for new safe devices.~~
- x. ~~Laguna Honda Department of Education and Training (LHH-DET) shall:~~
- ~~i. Develop and provide initial training during orientation to all new employees.~~
  - ~~ii. Develop and provide annual re-training for all employees.~~
  - ~~iii. Maintain all training records.~~
  - ~~iv. Meet annually with the Laguna Honda Industrial Hygienist and the Laguna Honda Infection Control Nurse to review the training curriculum pertaining to engineering controls, safety devices and work practices.~~
- xi. ~~Laguna Honda Nursing Education Department shall:~~
- ~~i. Develop and provide clinical safe device, needleless device, non-needle sharp and other engineering control training to Laguna Honda employees.~~
- xii. ~~Laguna Honda Product Evaluation Committee shall:~~
- ~~i. Incorporate bloodborne pathogen exposure surveillance findings and recommendations approved by the LHH-ICC and DPH-BPSDC into their product evaluation process.~~
- xiii. ~~Laguna Honda General Services Department shall:~~

~~Ensure that contaminated materials, linen and other regulated wastes are handled and disposed of in accordance with Laguna Honda Infection Control and Bloodborne Pathogen Programs.~~

#### ~~1. Exposure Determination:~~

- ~~a. All employees (unless specifically excluded) are included in the Laguna Honda BBPECP Orientation and annual training, because few employees at Laguna Honda have no risk of occupational exposure.~~
- ~~b. A list of job classifications with potential exposures to transmissible bloodborne pathogens is provided in Appendix B.~~

#### ~~Sharps Injury Prevention:~~

- ~~c. Exposure Reporting:~~

~~The employee immediately calls the Needlestick Hotline whenever he/she has been exposed to blood and body fluid. Hotline medical practitioners evaluate the exposure and direct the employee for further medical evaluation and treatment as indicated. The employee should report to the SFDPH-OHS for the scheduled appointment.~~

~~As part of the medical evaluation and treatment procedure by SFDPH-OHS, the exposed employee fills out the Blood or Body Fluid Exposure Report Form based on his/her best knowledge of the incident (Appendix A).~~

- ~~d. Sharps Injury Log Management~~

~~A copy of each Blood and Body Fluid Exposure Report Form is forwarded from the SFDPHOHS Clinic to the SFDPH-OSH Section. The information is recorded into the database within 14 days and the Sharps Injury Log is generated. Data is compiled by calendar year.~~

- ~~xiv. Sharps Injury Log Analysis~~

~~The LHH-ICC and DPH-BPSDC will regularly review Sharps Injury Log data as described above to analyze and update work practices and safety device use.~~

#### 1. Methods of Compliance

- a. Engineering Controls

- ~~i. Body Substance Precaution:~~

~~i. All employees are instructed to shall use standard precautions when caring for residents with the potential for exposure to body substances according to 72-01 Infection Control Manual B1 Standard Precautions.~~

~~ii.~~

~~i. Body Substance Precaution is a method of infection control which incorporates Universal Precautions and goes further to use barriers such as gloves, protective clothing and protective shields whenever an employee touches or may possibly be splashed by any body substance from any patient, regardless of the patient's diagnosis.~~

~~ii. Engineering and Work Practice Controls:~~

~~iii.~~

~~iv. When feasible, engineering controls will be implemented to limit employee exposures to blood and OPIM.~~

~~v.~~

~~ii. An engineering control is not required if a licensed healthcare professional reasonably determines, that the use of the control will jeopardize the resident's safety or the success of the procedure. Such resident safety determinations will be documented and provided to Laguna Honda LHH Infection Control Committee (ICC) and DPH Bloodborne Pathogen Safe Device Committee (BPSDC) for review.~~

~~iii. Needleless Systems will be used for:~~

~~b. Work Practices will be developed to minimize splashing, spraying, spattering and generation of droplets.~~

~~iii. An engineering control is not required if a licensed healthcare professional reasonably determines, that the use of the control will jeopardize the resident's safety or the success of the procedure.~~

~~iv. Such resident safety determinations will be documented and provided to LHH ICC and DPH BPSDC for review.~~

~~Needleless Systems:~~

~~v. Needleless systems will be used for:~~

- ~~• Withdrawal of body fluids,~~
- ~~• Accessing a vein or artery,~~
- ~~• Administration of medications or fluids,~~
- ~~• Any procedure involving the potential for an exposure incident for which a needleless device is available.~~

iv. Safe nNeedle dDevices :- shall be used if needleless systems are not available for the above mentioned procedures.

v. If sharps other than needle devices are used, these items shall include engineered sharps injury protection.

b. Work Practice Controls

i. Employees shall follow the hand hygiene and PPE procedures, safe injection practices, and environmental controls detailed in 72-01 Infection Control Manual B1 Standard Precautions.

ii. Needle clippers and other devices which shear, bend, or break contaminated needles or other contaminated sharps are prohibited.

iii. Eating, drinking, smoking, applying cosmetics and lip balm and handling contact lenses in any work areas where there is a reasonable likelihood of occupational exposure is prohibited.

iv. Food and drink shall not be kept in freezers, refrigerators, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.

~~d. Shall be used if needleless systems are not available for the above mentioned procedures.~~

~~e. \_\_\_\_\_~~

~~f. Non-Needle Devices~~

~~g. \_\_\_\_\_~~

~~h. If sharps other than needle devices are used, these items shall include engineered sharps injury protection.~~

~~i. \_\_\_\_\_~~

~~j. Handwashing:~~

~~k. \_\_\_\_\_~~

~~l. Accessible handwash facilities will be provided~~

~~m. \_\_\_\_\_~~

~~n. Employees shall follow the Laguna Honda Hand Hygiene Procedure as outline in the Laguna Honda Infection Control Manual.~~

~~o. \_\_\_\_\_~~

~~p. Sharps Handling:~~

~~q. \_\_\_\_\_~~

~~r. Contaminated needles shall not be recapped or removed from syringes.~~

~~s. \_\_\_\_\_~~

~~t. Needle clippers and other devices which shear, bend, or break contaminated needles or other contaminated sharps are prohibited.~~

~~u. \_\_\_\_\_~~

iii. Disposable sharps shall not be reused.

d. Cleaning

- i. Equipment, linens, resident clothing, and blood spills shall all be handled according to the procedures in Section F of 72-01 Infection Control Manual.

v.e. Sharps Disposal:

- i. Sharps that are contaminated with blood or any other body substance shall be placed in— appropriate disposal containers. The containers shall be:
  - puncture resistant,
  - labeled appropriately,
  - leak-proof on the sides and bottom, and
  - provide for safe handling by housekeeping staff.
- ii. Sharps disposal containers shall be easily accessible in areas where sharps waste may be generated. Sharps disposal containers shall be placed or positioned as close as possible to the site of the procedure so that contaminated sharps are easily disposed of immediately after use.
- iii. Employees ~~shall~~must never reach by hand into a sharps disposal container.
- iv. Sharps containers, when three quarters (3/4) filled, shall have their tops securely closed so that no spillage can occur and shall be replaced.
- v. The Environmental Services Department shall be responsible for appropriate disposal of filled sharps disposal containers.
- vi. Broken glassware that may be contaminated with body substances shall not be directly handled with a gloved or bare hand. It shall be handled by mechanical means such as tongs or dustpan and broom. Contaminated broken glass shall be placed in a puncture-resistant container and disposed of as biohazardous waste.

~~iii.—Sharp container contents will not be accessed unless properly reprocessed or decontaminated.~~

- ~~vii.~~ Sharps containers will not be opened, emptied or cleaned in any manner that may expose an employee.

~~viii.~~

~~b.—Prohibited Activities in Work Area:~~

i.vii.

- ~~iv. Eating, drinking, smoking, applying cosmetics and lip balm and handling contact lenses in any work areas where there is a reasonable likelihood of occupational exposure is prohibited.~~
- ~~v. Food and drink shall not be kept in freezers, refrigerators, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.~~
- ~~c. Cleaning of Worksite:~~
  - ~~i. All equipment and work surfaces will be cleaned with an appropriate disinfectant immediately or as soon as feasible when:~~
    - ~~• Surfaces become overtly contaminated.~~
    - ~~•~~
    - ~~• There is a blood or other infectious material spill.~~
    - ~~•~~
    - ~~• Procedures are completed.~~
    - ~~•~~
    - ~~• At the end of shift.~~
- ~~d. Laundry:~~
  - ~~i. All soiled linen and laundry are considered infectious and handled according to Body Substance Precautions.~~
  - ~~ii. Contaminated (moist with blood or other potentially infectious materials) linen or laundry shall be placed in plastic, leak-proof bags at the location where it was used.~~
  - ~~iii. Contaminated laundry is transported in covered trailers identified with biological hazard sign.~~
  - ~~vi. Laundry employees who sort contaminated laundry shall wear protective gowns, gloves, mask, disposable head caps, booties and other appropriate PPE.~~
- ~~e. Specimen Handling and Transport:~~
  - ~~i. Body Substance Precautions are practiced in obtaining, transporting, and handling all fluid or tissue specimens at Laguna Honda, negating the use of special labels.~~
  - ~~ii. All specimens of blood or other potentially infectious materials shall be placed in a primary container and a secondary see-through plastic bag (Ziploc) which contains any leakage during collection, handling, processing,~~



- ~~storage, transport or shipping. This containment also permits the employee to see broken and/or leaking containers.~~
- ~~vii. Within each campus building, blood specimens in vacutainer tubes may be transported in phlebotomy trays and/or carts without a secondary container.~~
- ~~iii. Specimen containers for transport or shipping outside of the Laguna Honda campus shall be packed according to the National Institute of Health (NIH)/Center for Disease Control (CDC) standards as detailed in the Laguna Honda Infection Control Manual and labeled with the universal biohazard symbol prior to transport.~~
- ~~f. Reusable Equipment:~~
- ~~i. Instruments or devices that enter tissues or the vascular system of any patient or through which blood flows, shall be sterilized or receive high-level disinfection.~~
- ~~ii. Medical devices or instruments that require disinfection or sterilization must be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide shall be followed.~~
- ~~g. Equipment Transport, Cleaning and Servicing:~~
- ~~i. Any equipment which is contaminated with blood or other potentially infectious materials shall be examined and decontaminated as necessary prior to transport unless the user can demonstrate that decontamination of such equipment or parts of such equipment is not feasible. Equipment or areas of equipment that cannot be decontaminated shall be labeled with the universal biohazard symbol.~~
- ~~ii. The individual sending contaminated equipment shall ensure that information regarding contamination is conveyed to the receiving employees, servicing representatives, and any other affected personnel prior to transport so that adequate precautions can be taken.~~

## ~~2. Personal Protective Equipment (PPE):~~

- ~~a. If the potential for exposure remains after institution of engineering and work practice controls, Laguna Honda employees will be provided with appropriate PPE.~~
- ~~b. Managers and supervisors shall ensure that PPE be available, that employees use PPE appropriately, and that training in the proper use of such equipment is provided.~~

- ~~c. Individual employees shall use PPE during work practices that may expose them to blood, body fluids, or other potentially infectious material.~~
- ~~d. An employee may temporarily and briefly decline to use the PPE, under extenuating circumstances described below, in which their professional judgment suggest that the PPE:
  - ~~i. Potentially interferes with providing health care or public safety emergency service~~
  - ~~ii. Potentially poses an increased hazard to the safety of the employee or co-workers
    - ~~• When this judgment is made, the supervisor shall investigate and document the circumstances in order to determine whether changes can be instituted to prevent such occurrences in the future.~~~~~~
- ~~e. PPE in appropriate quantities and sizes shall be readily accessible at the worksite.~~
- ~~f. PPE shall be removed prior to leaving work area.~~
- ~~g. Used PPE should be placed in a designated container or location for storage, cleaning or decontamination.~~
- ~~h. Gloves shall be worn whenever contact with blood or other body substances are anticipated.~~
- ~~i. Gloves shall be replaced as soon as possible after they are contaminated, torn or otherwise rendered ineffective.~~
- ~~j. Utility gloves (for non-patient care use only) may be decontaminated for re-use if the integrity of the glove has not been compromised.~~
- ~~k. Masks in combination with eye protection devices, such as goggles, should be worn whenever there is a potential for splash, spray, spatter, of blood or body substances.~~
- ~~l. Gowns, aprons, or other similar coverings shall be worn when there is potential exposure of blood or body substances to clothing or skin. The appropriate type of outer garment shall be based on the task and degree of exposure anticipated. Contaminated coverings shall be changed as soon as practical.~~
- ~~m. Resuscitation Devices shall be readily accessible to employees who may have reasonably anticipated needs to perform cardiopulmonary resuscitation.~~

## **2. Hepatitis B Vaccination**

- a. The Hepatitis B vaccine shall be offered to all employees and hospice volunteers who are at risk of occupational exposure to transmissible bloodborne pathogens within 10 working days of hire or reassignment to a job or tasks that place the employee at risk of exposure to blood and body fluids.
- b. If the individual initially declines the Hepatitis B vaccine series but at a later date decides to accept it, then the vaccination shall be provided.
- c. Any individual who declines the Hepatitis B vaccination shall sign the Hepatitis B informed consent/refusal form (Appendix B). This declination will be kept in the employee health record.

## **3. Post-Exposure Evaluation and Follow-Up:**

- a. In the event of an exposure incident, the involved employee must call the Needlestick Hotline (415-469-4411) as soon as possible and report the exposure to the Needlestick Hotline on-call clinician.
  - i. The Needlestick Hotline is available 24 hours/day, 7 days a week. The Needlestick Hotline will advise the employee to report the specifics of the incident to the Manager/ Supervisor.
  - ii. The Needlestick Hotline on-call clinician will request the name of the exposed employee, their work location, telephone number, and a history of the exposure event. If the Needlestick Hotline on-call clinician agrees that the exposure poses a possible risk for the transmission of bloodborne pathogens, Post-Exposure Prophylaxis (PEP) will be initiated, as medically indicated. The supervisor is responsible for providing and/or completing the DPH Occupational Safety and Health Section (DPH OSH) Worker's compensation Forms.
  - iii. The Needlestick Hotline on-call clinician will advise the employee to as appropriate for immediate Post-Exposure Prophylaxis (PEP).
  - iv. The Needlestick Hotline on-call clinician will contact and inform the Department of Public Health Occupational Health Service (OHS) provider.
  - v. Testing of the source individual for HIV will be coordinated and performed by a designated ~~Laguna Honda~~LHH physician who is informed of the exposure by the OHS Clinic.
  - vi. Results of the source individual's testing shall be made available to the exposed employee as well as the clinicians caring for the employee, and the employee shall be informed of the laws/regulations regarding the privacy

- rights for disclosure of the identity and infectious status of the source individual.
- b. The employee will report to the OHS Clinic located in Bldg. 9, 2nd floor Room 200. The OHS provider will:
- i. Provide risk assessment of the specific exposure and provide information about infection risk for HIV, HBV, and HCV.
  - ii. Discuss the risks and benefits of the recommended treatment plan.
  - iii. Obtain and order the appropriate laboratory tests with the employee's consent. HIV pretest counseling is provided prior to obtaining consent to HIV serological testing. Laboratory specimens will be sent to the ZSFG clinical lab with a coded number system without any personal identifiers. If the employee elects to have blood drawn but not to consent for HIV testing, the serum sample shall be stored for at least 90 days. If, within that 90 days the employee chooses to have the baseline sample tested, such testing shall be completed as soon as feasible.
  - iv. Have the employee complete the DPH Blood or Body Fluid Exposure Report (Appendix C) and document the circumstances of the exposure, treatment given, in the employee's medical record.
  - v. Complete the "Doctor's First Report of Injury" form; and
  - vi. If the employee refuses treatment, document all relevant information given to the employee, including the potential consequences of declining to follow the recommended course of action.
- c. The evaluating OHS health care clinician shall provide the exposed employee the following information:
- vii. Documentation of the route(s) of exposure and circumstances under which exposure occurred.
  - viii. Results of the source individual's blood testing for HIV, HCV and HBV, if available, or documentation that testing was not done due to lack of consent or other reasons.
  - ix. Medical records information relevant to the appropriate treatment of the employee, including vaccination status.
- d. When laboratory test results become available, the OHS provider shall inform the employee of the test results and evaluate the need to have the employee continue the PEP in relation to the employee's test results and the source

patient's bloodborne infection status, if available. The OHS clinician will arrange to continue follow-up care, if indicated.

e. The evaluating OHS clinician shall provide the employee with a copy of a written opinion within 15 days of the completion of the evaluation.

i. The written opinion for Hepatitis B vaccination shall be limited to whether the vaccine is indicated and if the employee has received such vaccination.

ii. The written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

- The employee has been informed of the results of the evaluation.
- The employee has been told about any medical conditions resulting from the exposure, which require further evaluation or treatment.

iii. Other findings or diagnoses shall remain confidential and shall not be included in the written report.

a. Sharps Injury Log:

i. The OHS provider will send a copy of the Blood or Body Fluid Exposure Report Form completed by the employee to the DPH OSH Section. This information is entered into an exposure database within 14 days and the Sharps Injury Log is generated. Data is compiled by calendar year.

ii. The ICC and BPSDC shall review the Sharps Injury Log data as described above to analyze and update work practices and safety device use.

#### **4. Communication of Hazards:**

a. Labels:

i. Warning labels incorporating the universal biohazard sign and the word, "biohazard," shall be printed on or affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material or any other containers used to store, transport or ship blood or other potentially infectious materials outside of the [Laguna Honda LHH](#) campus.

ii. Labels shall be affixed to contaminated equipment and/or equipment containers.

iii. Containers of blood, blood products, or blood components that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from labeling requirements.

- iv. The labels shall be fluorescent orange or orange-red with lettering or symbols in a contrasting color.
- v. Labels shall be affixed as securely as possible to the container, preferably by adhesive, or by wire, string or other method that prevents their loss or unintentional removal.

b. Training:

- i. ~~LHH-DET shall provide general training to Laguna Honda occupationally exposed employees employees and volunteers at the time of initial assignment and annually.~~
- c. ~~NON-Laguna Honda employees will be trained by the primary employer unless otherwise specified in writing between Laguna Honda and the outside agency.~~
- ii. Annual training will be live or computer-based. ~~In the case of computer based training, LHH-DET shall~~ will provide a phone or pager number to provide immediate access to a qualified individual to which questions can be addressed.
- iii. Additional training shall be provided whenever modifications of work practices or engineering controls are introduced.
- iv. The Bloodborne Pathogen Exposure Control Training will include:

~~Frequency of General Training:~~

~~At the time of initial assignment to tasks where occupational exposure may occur.~~

~~At least annually after the initial training.~~

~~When modifications of work practices or engineering controls are introduced.~~

d. ~~General Curriculum for Bloodborne Pathogen Exposure Control~~

- Copy and Text of Standard for Bloodborne Pathogen Exposure Control explanation of the contents and accessibility of the applicable CAL-OSHA Regulations.
- Epidemiology and Symptoms: a general explanation of the epidemiology and symptoms of bloodborne diseases.

- Modes of Transmission: an explanation of the modes of transmission of bloodborne pathogens.
- Laguna Honda LHH BBPECP: an explanation of the Laguna Honda LHH exposure control ~~program plan~~ and its availability to each employee.
- Risk Identification: an explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and ~~other potentially infectious materials~~ OPIM.
- Methods of Compliance: an explanation of the use and limitations of methods that may prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.
- Decontamination and Disposal: information on the selection and maintenance of PPE including types, proper use, location, removal, handling, decontamination and disposal.
- Personal Protective Equipment: an explanation of the basis for selection of personal protective equipment.
- Hepatitis B Vaccination: information on the hepatitis B vaccine, including information on its safety, efficacy, method of administration, the benefits of being vaccinated.
- Emergency: information on the appropriate actions to take and the persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure Incident: an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
- Post-Exposure Evaluation and Follow-Up: information on the post-exposure evaluation and follow-up that ~~DPH~~ OHS Clinic will provide.
- Signs and Labels: an explanation of the signs and labels and/or color coding.

~~e. Unit Specific Training~~

- ~~i. Unit Specific Training pertaining to clinical work practices, safety devices and other engineering controls that are unique to a given unit or work environment will be provided to the applicable employees.~~

- ii. ~~Unit specific and hands-on device training will be provided by Laguna Honda Nursing Education Department or manufacturer.~~

**6. ~~Hepatitis B Vaccination:~~**

~~7.~~

- a. ~~The Hepatitis B vaccine shall be offered to all employees and hospice volunteers who are at risk of occupational exposure to transmissible bloodborne pathogens within 10 working days of hire or reassignment to a job or tasks that place the employee at risk of exposure to blood and body fluids.~~
- b.
- c. ~~If the individual initially declines the Hepatitis B vaccine series but at a later date decides to accept it, then the vaccination shall be provided.~~
- d.
- e. ~~Any individual who declines the Hepatitis B vaccination shall sign the Hepatitis B declination form (Appendix C). This declination will be kept in the employee health record.~~

~~8.~~

**9. ~~Post-Exposure Management:~~**

a. ~~Needlestick Hotline~~

- i. ~~In the event of an exposure incident, the involved employee must call the Needlestick Hotline (469-4411) as soon as possible and report the exposure to the Needlestick Hotline on-call clinician. The Needlestick Hotline is available 24 hours/day, 7 days a week. The Needlestick Hotline will advise the employee to report the specifics of the incident to the Manager/Supervisor.~~
- ii. ~~The Needlestick Hotline on-call clinician will request the name of the exposed employee, their work location, telephone number, and a history of the exposure event. If the Needlestick Hotline on-call clinician agrees that the exposure poses a possible risk for the transmission of bloodborne pathogens, Post-Exposure Prophylaxis (PEP) will be initiated, as medically indicated. The supervisor is responsible for providing and/or completing the DPH-OSH Worker's compensation Forms.~~
- iii. ~~The Needlestick Hotline on-call clinician will advise the employee to as appropriate for immediate Post-Exposure Prophylaxis (PEP).~~
- iv. ~~The Needlestick Hotline on-call clinician will contact and inform the Occupational Health Service (OHS) provider.~~
- v. ~~Testing of the source individual for HIV will be coordinated and performed by a designated Laguna Honda physician who is informed of the exposure by the DPH OHS Clinic.~~



~~vi. Results of the source individual's testing shall be made available to the exposed employee as well as the clinicians caring for the employee, and the employee shall be informed of the laws/regulations regarding the privacy rights for disclosure of the identity and infectious status of the source individual.~~

~~b. Occupational Health Services:~~

~~The employee will report to the DPH OHS Clinic located in Bldg. 9, 2nd floor Room 200. The OHS provider will:~~

~~i. Discuss the circumstances of the exposure and identify and discuss changes in work practice or technique, if any that may be warranted to prevent accidents in the future.~~

~~ii. Provide risk assessment of the specific exposure and provide information about infection risk for HIV, HBV, and HCV.~~

~~iii. Discuss the risk and benefits of the recommended treatment plan.~~

~~iv. Obtain and order the appropriate laboratory tests with the employee's consent. HIV pretest counseling is provided prior to obtaining consent to HIV serological testing.~~

~~Laboratory specimens will be sent to the clinical lab with a coded number system without any personal identifiers. If the employee elects to have blood drawn but not to consent for HIV testing, the serum sample shall be stored for at least 90 days. If, within that 90 days the employee chooses to have the baseline sample tested, such testing shall be completed as soon as feasible.~~

~~v. Complete the "Doctor's First Report of Injury" form; and~~

~~vi. Document the circumstances of the exposure, treatment given, in the Employees' Compensation medical record.~~

~~vii. If the employee refuses treatment, documents all relevant information given to the employee, including the potential consequences of declining to follow the recommended course of action.~~

~~When laboratory test results become available, the OHS provider informs the employee of the test results and evaluates the need to have the employee continue the PEP in relation to the employee's test results and the source patient's bloodborne infection status, if available. The OHS clinician will arrange to continue follow-up care, if indicated.~~

~~The evaluating OHS health care clinician shall provide the exposed employee the following information:~~

- ~~viii. Documentation of the route(s) of exposure and circumstances under which exposure occurred.~~
- ~~ix. Results of the source individual's blood testing for HIV, HCV and HBV, if available, or documentation that testing was not done due to lack of consent or other reasons.~~
- ~~x. Medical records information relevant to the appropriate treatment of the employee, including vaccination status.  
The evaluating OHS clinician shall provide the employee with a copy of a written opinion within 15 days of the completion of the evaluation.~~
- ~~xi. The written opinion for Hepatitis B vaccination shall be limited to whether the vaccine is indicated and if the employee has received such vaccination.~~
- ~~xii. The written opinion for post-exposure evaluation and follow-up shall be limited to the following information:
  - ~~• The employee has been informed of the results of the evaluation.~~
  - ~~• The employee has been told about any medical conditions resulting from the exposure, which require further evaluation or treatment.~~
  - ~~• Other findings or diagnoses shall remain confidential and shall not be included in the written report.~~~~

## 5. Recordkeeping

### b. Employee Health Records

- i. The OHS Clinic shall establish and maintain an accurate medical record for each employee with occupational exposure.
- ii. Ensure that the health care employee records are kept confidential and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this Standard and by law.
- iii. Maintain the records for at least the duration of employment plus 30 years in accordance with this Standard.
- iv. The ~~Laguna Honda~~LHH Medical Clinic will maintain records of immunization and declination forms pertaining to Hepatitis B vaccinations.

### b. Training Records

LHH-DET will maintain all employee training records for three (3) years after training is provided.

**10. Program Evaluation:**

11.6.

~~The LHH-ICC will conduct on-going program evaluation and complete required updates.~~

- a. ~~Evaluation of the Laguna Honda BBPECP will occur at least~~ The Laguna Honda LHH Occupational Safety and Health Committee and the ICC will review the BBP Plan annually and/or whenever the following circumstance(s) occur:
  - i. Introduction or modification of work practices.
  - ii. Introduction or modification of technologies or engineering controls.
  - iii. Introduction or modification of classifications.
  - iv. Indications of deficiencies.
- b. Input from employees providing direct patient care will be solicited by the committees during each annual review.

**Recordkeeping:**

~~Employee Health~~

~~The SFDPH Clinic shall establish and maintain the following:~~

~~An accurate medical record for each employee with occupational exposure.~~

~~Ensure that the health care employee records are kept confidential and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this Standard and by law.~~

~~Maintain the records for at least the duration of employment plus 30 years in accordance with this Standard.~~

~~Training Records~~

~~LHH-DET will maintain training records of employees and volunteers for three (3) years from the date on which the training occurred.~~

~~Immunization Records and Declination Forms~~

~~Laguna Honda Medical Clinic will create and maintain records of immunization and declination forms pertaining to Hepatitis B employee vaccinations.~~

**ATTACHMENT:**

Appendix A: ~~Determination of Exposures (classification list)~~ Blood/Body Fluid Exposure Report Form

Appendix B: Hepatitis B Informed Consent/Refusal Form ~~Determination of Exposures (classification list)~~

Appendix C: Blood/Body Fluid Exposure Report Form ~~Hepatitis B Declination Form~~

Appendix D: ~~Cal-OSHA Title 8, 5193~~

**REFERENCE:**

~~None.~~ Cal-OSHA Title 8, 5193

Revised: 07/08/28, 13/05/28, 15/01/13 (Year/Month/Day)

Approved for renumbering from 72-02 to 73-06: 15/01/13

**Appendix A: Exposure Determination**

**Exposure Category 1: Employees providing direct resident care with possible exposure to blood and/or other potentially infectious material**

<u>Class</u>	<u>Title</u>
<u>2202</u>	<u>Dental Aide</u>
<u>2210</u>	<u>Dentist</u>
<u>2230</u>	<u>Physician Specialist</u>
<u>2232</u>	<u>Senior Physician Specialist</u>
<u>2302</u>	<u>Nursing Assistant</u>
<u>2303</u>	<u>Patient Care Assistant</u>
<u>2312</u>	<u>Licensed Vocational Nurse</u>
<u>2320</u>	<u>Registered Nurse</u>
<u>2322</u>	<u>Nurse Manager</u>
<u>2323</u>	<u>Clinical Nurse Specialist</u>
<u>2324</u>	<u>Nursing Supervisor</u>
<u>2326</u>	<u>Nursing Supervisor Psychiatric</u>
<u>2390</u>	<u>Central Processing &amp; Dist Tech</u>
<u>2392</u>	<u>Sr Cent Proc &amp; Dist Tech</u>
<u>2536</u>	<u>Respiratory Care Practitioner</u>
<u>2583</u>	<u>Home Health Aide</u>
<u>2736</u>	<u>Porter</u>
<u>2740</u>	<u>Porter Supervisor 1</u>
<u>7324</u>	<u>Beautician</u>
<u>P103</u>	<u>Special Nurse</u>

**Exposure Category 2: Employees with resident contact or other job duties that may result in exposure to blood and/or other potentially infectious material**

<u>Class</u>	<u>Title</u>
<u>1428</u>	<u>Unit Clerk</u>
<u>2424</u>	<u>X-Ray Laboratory Aide</u>
<u>2430</u>	<u>Medical Evaluations Assistant</u>
<u>2450</u>	<u>Pharmacist</u>
<u>2454</u>	<u>Clinical Pharmacist</u>
<u>2468</u>	<u>Diagnostic Imaging Tech II</u>
<u>2469</u>	<u>Diagnostic Imaging Tech III</u>
<u>2542</u>	<u>Speech Pathologist</u>
<u>2548</u>	<u>Occupational Therapist</u>
<u>2550</u>	<u>Senior Occupational Therapist</u>
<u>2554</u>	<u>Therapy Aide</u>

<a href="#">2555</a>	<a href="#">Physical Therapist Assistant</a>
<a href="#">2556</a>	<a href="#">Physical Therapist</a>
<a href="#">2558</a>	<a href="#">Senior Physical Therapist</a>
<a href="#">2574</a>	<a href="#">Clinical Psychologist</a>
<a href="#">2576</a>	<a href="#">Sprv Clinical Psychologist</a>
<a href="#">2587</a>	<a href="#">Health Worker 3</a>
<a href="#">2588</a>	<a href="#">Health Worker 4</a>
<a href="#">2591</a>	<a href="#">Health Program Coordinator 2</a>
<a href="#">2593</a>	<a href="#">Health Program Coordinator 3</a>
<a href="#">2604</a>	<a href="#">Food Service Worker</a>
<a href="#">2622</a>	<a href="#">Dietetic Technician</a>
<a href="#">2624</a>	<a href="#">Dietitian</a>
<a href="#">2626</a>	<a href="#">Chief Dietitian</a>
<a href="#">2738</a>	<a href="#">Porter Assistant Supervisor</a>
<a href="#">2785</a>	<a href="#">Asst General Services Manager</a>
<a href="#">2846</a>	<a href="#">Nutritionist</a>
<a href="#">2903</a>	<a href="#">Eligibility Worker</a>
<a href="#">2908</a>	<a href="#">Hospital Eligibility Worker</a>
<a href="#">2913</a>	<a href="#">Program Specialist</a>
<a href="#">2920</a>	<a href="#">Medical Social Worker</a>
<a href="#">2922</a>	<a href="#">Senior Medical Social Worker</a>
<a href="#">2924</a>	<a href="#">Medical Social Work Supervisor</a>
<a href="#">2930</a>	<a href="#">Psychiatric Social Worker</a>
<a href="#">2931</a>	<a href="#">Marriage, Family &amp; Child Cnslr</a>
<a href="#">4321</a>	<a href="#">Cashier 2</a>
<a href="#">6138</a>	<a href="#">Industrial Hygienist</a>
<a href="#">6139</a>	<a href="#">Senior Industrial Hygienist</a>
<a href="#">7334</a>	<a href="#">Stationary Engineer</a>
<a href="#">7335</a>	<a href="#">Senior Stationary Engineer</a>
<a href="#">7347</a>	<a href="#">Plumber</a>
<a href="#">7524</a>	<a href="#">Institution Utility Worker</a>

**Exposure Category 3: Employees who do not provide direct resident care and do not have job duties that require contact with residents or potentially infectious material**

<b><u>Class</u></b>	<b><u>Title</u></b>
<a href="#">0922</a>	<a href="#">Manager I</a>
<a href="#">0923</a>	<a href="#">Manager II</a>
<a href="#">0931</a>	<a href="#">Manager III</a>
<a href="#">0932</a>	<a href="#">Manager IV</a>
<a href="#">0933</a>	<a href="#">Manager V</a>
<a href="#">0941</a>	<a href="#">Manager VI</a>

<a href="#"><u>0943</u></a> <a href="#"><u>Manager VIII</u></a>
<a href="#"><u>1022</u></a> <a href="#"><u>IS Administrator 2</u></a>
<a href="#"><u>1042</u></a> <a href="#"><u>IS Engineer-Journey</u></a>
<a href="#"><u>1043</u></a> <a href="#"><u>IS Engineer-Senior</u></a>
<a href="#"><u>1044</u></a> <a href="#"><u>IS Engineer-Principal</u></a>
<a href="#"><u>1052</u></a> <a href="#"><u>IS Business Analyst</u></a>
<a href="#"><u>1053</u></a> <a href="#"><u>IS Business Analyst-Senior</u></a>
<a href="#"><u>1054</u></a> <a href="#"><u>IS Business Analyst-Principal</u></a>
<a href="#"><u>1070</u></a> <a href="#"><u>IS Project Director</u></a>
<a href="#"><u>1071</u></a> <a href="#"><u>IS Manager</u></a>
<a href="#"><u>1093</u></a> <a href="#"><u>IT Operations Support Admn III</u></a>
<a href="#"><u>1165</u></a> <a href="#"><u>Manager, Department Of Public Health</u></a>
<a href="#"><u>1202</u></a> <a href="#"><u>Personnel Clerk</u></a>
<a href="#"><u>1204</u></a> <a href="#"><u>Senior Personnel Clerk</u></a>
<a href="#"><u>1220</u></a> <a href="#"><u>Payroll Clerk</u></a>
<a href="#"><u>1222</u></a> <a href="#"><u>Sr Payroll &amp; Personnel Clerk</u></a>
<a href="#"><u>1226</u></a> <a href="#"><u>Chief Payroll &amp; Personnel Clerk</u></a>
<a href="#"><u>1241</u></a> <a href="#"><u>Personnel Analyst</u></a>
<a href="#"><u>1244</u></a> <a href="#"><u>Senior Personnel Analyst</u></a>
<a href="#"><u>1404</u></a> <a href="#"><u>Clerk</u></a>
<a href="#"><u>1406</u></a> <a href="#"><u>Senior Clerk</u></a>
<a href="#"><u>1408</u></a> <a href="#"><u>Principal Clerk</u></a>
<a href="#"><u>1429</u></a> <a href="#"><u>Nurses Staffing Assistant</u></a>
<a href="#"><u>1430</u></a> <a href="#"><u>Transcriber Typist</u></a>
<a href="#"><u>1440</u></a> <a href="#"><u>Medical Transcriber Typist</u></a>
<a href="#"><u>1630</u></a> <a href="#"><u>Account Clerk</u></a>
<a href="#"><u>1632</u></a> <a href="#"><u>Senior Account Clerk</u></a>
<a href="#"><u>1634</u></a> <a href="#"><u>Principal Account Clerk</u></a>
<a href="#"><u>1635</u></a> <a href="#"><u>Health Care Billing Clerk 1</u></a>
<a href="#"><u>1636</u></a> <a href="#"><u>Health Care Billing Clerk 2</u></a>
<a href="#"><u>1652</u></a> <a href="#"><u>Accountant II</u></a>
<a href="#"><u>1654</u></a> <a href="#"><u>Accountant III</u></a>
<a href="#"><u>1657</u></a> <a href="#"><u>Accountant IV</u></a>
<a href="#"><u>1662</u></a> <a href="#"><u>Patient Accounts Asst Sprv</u></a>
<a href="#"><u>1663</u></a> <a href="#"><u>Patient Accounts Supervisor</u></a>
<a href="#"><u>1664</u></a> <a href="#"><u>Patient Accounts Manager</u></a>
<a href="#"><u>1708</u></a> <a href="#"><u>Senior Telephone Operator</u></a>
<a href="#"><u>1820</u></a> <a href="#"><u>Junior Administrative Analyst</u></a>
<a href="#"><u>1822</u></a> <a href="#"><u>Administrative Analyst</u></a>
<a href="#"><u>1823</u></a> <a href="#"><u>Senior Administrative Analyst</u></a>
<a href="#"><u>1824</u></a> <a href="#"><u>Pr Administrative Analyst</u></a>

<u>1825</u>	<u>Prnpl Admin Analyst II</u>
<u>1842</u>	<u>Management Assistant</u>
<u>1934</u>	<u>Storekeeper</u>
<u>1942</u>	<u>Asst Materials Coordinator</u>
<u>1944</u>	<u>Materials Coordinator</u>
<u>2105</u>	<u>Patient Svcs Finance Tech</u>
<u>2106</u>	<u>Med Staff Svcs Dept Spc</u>
<u>2110</u>	<u>Medical Records Clerk</u>
<u>2112</u>	<u>Medical Records Technician</u>
<u>2114</u>	<u>Medical Records Tech Sprv</u>
<u>2119</u>	<u>Health Care Analyst</u>
<u>2406</u>	<u>Pharmacy Helper</u>
<u>2409</u>	<u>Pharmacy Technician</u>
<u>2453</u>	<u>Supervising Pharmacist</u>
<u>2606</u>	<u>Senior Food Service Worker</u>
<u>2608</u>	<u>Supply Room Attendant</u>
<u>2618</u>	<u>Food Service Supervisor</u>
<u>2619</u>	<u>Senior Food Service Supervisor</u>
<u>2620</u>	<u>Food Service Mgr Administrator</u>
<u>2650</u>	<u>Assistant Cook</u>
<u>2654</u>	<u>Cook</u>
<u>2656</u>	<u>Chef</u>
<u>2818</u>	<u>Health Program Planner</u>
<u>2909</u>	<u>Hospital Elig Wrk Supervisor</u>
<u>3417</u>	<u>Gardener</u>
<u>7120</u>	<u>Bldgs &amp; Grounds Maint Supt</u>
<u>7203</u>	<u>Bldg &amp; Grounds Maint Sprv</u>
<u>7205</u>	<u>Chief Stationary Engineer</u>
<u>7342</u>	<u>Locksmith</u>
<u>7344</u>	<u>Carpenter</u>
<u>7345</u>	<u>Electrician</u>
<u>7346</u>	<u>Painter</u>
<u>7355</u>	<u>Truck Driver</u>
<u>9910</u>	<u>Public Service Trainee</u>
<u>9924</u>	<u>PS Aide Health Services</u>



**Appendix C: Blood/Body Fluid Exposure Report Form**

## **AEROSOL TRANSMISSIBLE DISEASE (ATD) EXPOSURE CONTROL PLAN**

### **POLICY:**

The Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to maintaining a healthy work force by controlling occupational exposure of its employees to infectious diseases.

The Aerosol Transmissible Disease Exposure Control Plan (ATDP) is a program administered jointly by ~~the LHH~~ the Departments of Industrial Hygienist Workplace Safety and Emergency Management (WSEM), ~~the LHH Infection Control Nurse~~, and ~~LHH~~ Employee Health. The ATDP shall require the same responsibilities for supervisors, employees and designated staff as the Illness and Injury Prevention Program (IIPP).

### **PURPOSE:**

The purpose of the ATDP is to implement and maintain effective procedures for controlling occupational exposure to ATDs, consistent with LHH policy and pursuant to Title 8 of the California Code of Regulations, Section 5199.

### **PROCEDURE:**

#### **1. Definitions and Applicability of ATDP**

- a. Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP)

A disease or pathogen for which droplet or airborne precautions is recommended, as listed in Appendix A.

- b. Airborne Infectious Disease (AirID)

Either: (1) an ATD transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which airborne infection isolation is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet.

- c. Occupational Exposure

Occupational exposure is exposure from work activity that causes a higher risk of contracting disease than what would be considered ordinary for employees having direct contact with the general public outside of the healthcare setting. The ATDP applies to all LHH employees who have the potential to be occupationally exposed. Job classifications of potentially occupationally exposed employees are listed in Appendix B.

d. Ebola Virus Disease

This ATDP does not apply to Ebola Virus Disease (EVD). Laguna Honda employees will not treat patients with EVD and will, therefore, not be occupationally exposed to EVD. If any person in the facility is suspected of having EVD, they will be isolated and transported to an appropriate acute care hospital according to the Laguna Honda Ebola Response Plan.

e. High Hazard Procedures

High hazard procedures are procedures performed on a resident who is a case or suspected case of an ATD in which the potential for exposure to an aerosol transmissible pathogen is increased due to the reasonably anticipated generation of aerosolized pathogens.

## 2. Methods of Controlling Exposures

a. Source Control

In the event a LHH resident is suspected of having an ATD, the following procedure shall be followed prior to transfer to an isolation room:

- i. Resident will be instructed to remain at bedside with curtains drawn. If available, resident can be placed temporarily in a well-ventilated private room with doors closed.
- ii. If tolerated, the resident should be encouraged to wear a surgical mask.
- iii. Resident will be instructed to follow respiratory hygiene and cough etiquette protocol. This includes covering mouth and nose with tissue when coughing or sneezing, and to discard tissue in non-touch receptacle provided by nursing staff.
- iv. Resident shall be encouraged to practice hand hygiene. Hand washing facilities and, if appropriate, alcohol hand sanitizer shall be made available.
- v. Resident should only be allowed to leave room for essential purposes. If resident needs to leave the room he/she shall wear a surgical mask.
- vi. The Nurse Manager/Charge Nurse shall be responsible for notifying unit staff and other personnel of special precautions that need to be followed until re-location occurs. The nursing staff will be responsible for notifying the receiving department of suspected diagnosis and source control measures which should be implemented.

b. Procedures for Airborne Infection Isolation (All)

LHH has seven negative pressure All rooms. The room numbers of the All rooms are S628, S648, S528, S548, S428, S448, and PM56. Any resident who is identified as a case or suspected case of ATD will be transferred to an All room according to the following procedure.

- i. Notify the Infection Control Nurse who will make the determination if an All room is appropriate and work with the bed control coordinator to plan relocation. In the event that the Infection Control Nurse is not available the Nurse Manager on duty shall be notified.
- ii. ~~The Infection Control Nurse will contact the bed control coordinator and Nurse Manager/Charge Nurse on the unit with the isolation room to let them know that a resident will be transferred for airborne isolation.~~ The Charge Nurse of the neighborhood that the resident is currently on shall contact the Charge Nurse of the receiving neighborhood to discuss transfer arrangements for the resident requiring airborne isolation
- iii. The Infection Control Nurse/Nurse Manager on duty will notify the Watch Engineer that an isolation room will be activated. The Watch Engineer or other Stationary Engineer will assess and confirm the integrity of the negative pressure system and report back to the Infection Control Nurse/Nurse Manager on duty that the room is fit or unfit for occupancy.
- iv. Transfer to the All room must take place as soon as possible but no later than 5 hours after initial identification.
- v. The door to the isolation room will be labeled notifying staff to "STOP". Check with nurse before entering and N95 required.
- vi. The resident will be instructed to remain in the isolation room with the door closed.
- vii. ~~RN95~~ respirators and personal protective clothing will be made available in the ante room to all staff entering the isolation room. Additional supplies are available from Central supply.
- viii. Any staff member who enters an All room occupied by a resident with known or suspected AirID must wear an N95 or PAPR in accordance with the LHH Respiratory Protection Program (LHH 73-09). Employees who have not been medically cleared, fit tested and/or trained for N95 or PAPR use will not enter the All room.
- ix. Residents will receive all medical treatment in the All room. Movement and transport of residents out of the All room should be for medically essential

purposes only and the resident will wear a surgical type mask and be escorted by hospital staff.

**c. Maintenance of All Rooms**

- i. All room ventilation systems will be maintained, inspected and monitored by facility services for exhaust or re-circulation, filter loading and leakage at least annually, whenever filters are changed, and as needed.
- ii. Negative pressure will be maintained in All rooms occupied by a resident with known or suspected AirID with a ventilation rate of 12 or more air changes per hour (ACH). Negative pressure will be monitored continuously by the built-in, alarmed electronic monitor. Facility Services is responsible for negative pressure monitoring and recording of results. These records shall be maintained for a minimum of five years by the Chief Engineer.
- iii. In addition to electronic monitoring, negative pressure will be visually demonstrated daily in All rooms occupied by known or suspected AirID cases. This will be done by the Watch Engineer and results recorded in the Watch Engineer’s log.
- iv. When occupied by a resident with known or suspected AirID, doors and windows to the All room shall be kept closed at all times, except when doors are opened for entering or exiting.
- v. When a case or suspected case vacates an All room, the room shall be ventilated for 99.9% removal efficiency according to Table 1 below from the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings before anyone enters the room without PPE.

**TABLE 1. Air changes per hour (ACH) and time required for removal efficiencies of 99% and 99.9% of airborne contaminants\***

ACH	Minutes required for removal efficiency†	
	99%	99.9%
2	138	207
4	69	104
6	46	69
12	23	35
15	18	28
20	7	14
50	3	6
400	<1	1

\* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.

† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

e.d. Procedure When No Available All Room

- i. If no Isolation room is available, the resident will be transferred to another facility with an available isolation room as soon as possible but no later than 5 hours after identification.
- ii. The exception to the policy is if the unit physician or Medical Director has contacted SFDPH and determined that there is no airborne isolation room available in the county. This will be documented in the resident medical record after the initial 5 hours has passed and every 24hrs thereafter.
- iii. LHH staff will follow all environmental control measures specified by the Infection Control Nurse and SFDPH.
- iv. If the physician determines that transferring the resident would be detrimental to the resident's condition, the transfer can be put on hold. Employees caring for the resident, however, must use respiratory protection and PPE.     The resident's condition shall be reviewed every 24 hours and documentation made in the medical record.     Once determined that the resident can be safely transferred, transfer must be carried out per the protocol above.

d.e. Administrative and Work Practice Controls

- i. Hand hygiene guidelines must be followed at all times.
- ii. Designated isolation room treatment equipment will be utilized if possible. This includes, but is not limited to, BP cuffs, thermometers etc. The items will be dedicated to the resident in the isolation room until it is vacated.
- iii. Procedures for cleaning occupied isolation rooms shall be the same as the cleaning procedures used in exam rooms (see LHH 72-01 [Infection Control Manual](#) ~~Section G3F12~~) except that personnel performing cleaning procedures shall follow airborne precautions.
- iv. Terminal cleaning of non-disposable medical equipment will be done after each discharge according to LHH ~~Infection Control Policy Section 72-01~~ [Infection Control Manual F13G2](#). All other equipment will be discarded at discharge.
- v. Terminal cleaning of All rooms shall be done in accordance with LHH ~~Infection Control Manual 72-01~~ [Infection Control Manual Section F2](#) after ventilating according to section 2(c)(v) of this plan.

e.f. Respiratory Protection

- i. The following tasks require the use of at least an N95 respirator.
  - Working in an airborne isolation room occupied by a resident with known or suspected ATD, including both patient care and cleaning/maintenance tasks.
  - Transporting a resident with known or suspected ATD.
  - Maintaining or repairing the ventilation system for isolation rooms when the room is not occupied by a resident with known or suspected ATD.
- ii. A powered air purifying respirator (PAPR) must be worn for the following tasks:
  - Performing or assisting a high hazard procedure (see Table 2).
  - Performing maintenance or repair on the ventilation system for isolation rooms while a suspected or confirmed case of an AirID is occupying the room.
- iii. All respirator use shall be in accordance with the LHH Respiratory Protection Program (LHHPP 73-09 [Respiratory Protection Program \(RPP\)](#)).

**f.g. High Hazard Procedures**

All high hazard procedures listed in Table 2 will be controlled as follows when performed on a case or suspected case of AirID:

- i. High hazard procedures shall be conducted in the All room.
- ii. Only personnel necessary to perform the procedure shall be in the room during the procedure.
- iii. Powered Air Purifying Respirators (PAPRs) must be worn by all employees who are in the room during the procedure.

**Table 2. High Hazard Procedures and Job Classes Potentially Exposed**

Procedure	Job Classes	Job Titles
<ul style="list-style-type: none"> <li>• Sputum Induction</li> <li>• Respiratory Care (e.g. suctioning, trach care)</li> <li>• Nasal Aspirates</li> <li>• Aerosol Therapy (nebulizer)</li> <li>• Any other aerosol generating medical procedures</li> </ul>	2536 2320 2312 2230 2232 2302 2303 2583	Respiratory Care Practitioner Registered Nurse Licensed Vocational Nurse Physician Specialist Senior Physician Specialist Nursing Assistant Patient Care Assistant Home Health Aide

Procedure	Job Classes	Job Titles
<ul style="list-style-type: none"> <li>Maintenance/repair of isolation room ventilation systems when the room is occupied by a resident with a suspected or confirmed ATD</li> </ul>	7334 7335	Stationary Engineer Sr. Stationary Engineer

### 3. Medical Services

#### a. Vaccinations

- i. All employees will have available free of charge all vaccinations listed in Appendix C.
- ii. Employees shall ~~receive be offered~~ their initial vaccinations at the ~~SFGH OHSDPH Occupational Health Service (OHS) clinic at Zuckerberg San Francisco General Hospital (ZSFG)~~ during their pre-employment health exam. ~~After employees are hired they will receive subsequent vaccinations at the LHH Employee Health Clinic (LHH Clinic).~~
- iii. Influenza vaccinations will be available to staff during the period designated by the CDC.
- iv. Employees who decline vaccination must sign a declination form for the specified vaccine, which includes the statement in Appendix D. These forms once completed shall be maintained in the ~~Laguna Honda employee's LHH Employee Health record file.~~
- v. If an employee initially declines a vaccine they can anytime thereafter request and receive the vaccine from the ~~LHH Employee Health LHH~~ Clinic.
- vi. Employees who receive vaccinations which will protect them from exposures to ATD pathogens are still required to wear personal protective equipment, including respiratory protection when required by this policy.

#### b. Tuberculosis (TB) Surveillance Program

All employees will participate in the Tuberculosis Surveillance Program as follows.

- i. 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) OHS~~ or the ~~Outpatient Clinic at LHH LHH Clinic~~ will document the PPD administration or reason for not completing it.
- ii. The PPD skin test results will be maintained in the Employee Health records at ~~the Laguna Honda Outpatient LHH~~ Clinic.



- iii. All employees shall receive annual tuberculosis screening at ~~Laguna Honda~~ the LHH Clinic. 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.
- iv. Employees who convert their skin tests will receive a TB Symptom Review Survey, chest x-rays and referral to the ~~Tuberculosis OHS~~ Clinic at ~~SFGHZSFG~~. The results of the evaluation from the ~~OHS~~ SFGH Tuberculosis Clinic will be sent to the ~~LHH Clinic~~ aguna Honda Outpatient Clinic. The ~~OHS~~ Medical Director or ~~d~~ Designee will review these results and provide clearance for the employee to continue work.

#### 4. Exposure Incident Follow-Up

- a. Employees who suspect an occupational exposure to an ATD in the workplace will report the exposure immediately to their supervisor.
- b. The supervisor will notify the Infection Control Nurse and the Industrial Hygienist and will complete injury/incident paperwork (Forms DWC-1, SIIR, and 5020) and the) – Supervisor’s Airborne Transmissible Disease Exposure Report (Appendix E) to be faxed to the DPH Occupational Safety and Health Section (OSH) at 415-554-2570.
- c. If the Supervisor’s investigation determines that there has been an exposure to an ATD as a result of uncontrolled exposure to a resident with confirmed ATD:
  - i. The Infection Control Nurse and Industrial Hygienist will use the Supervisor’s Airborne Transmissible Disease Exposure Report to determine whether other employees and/or residents may have been exposed to the source resident while the resident was infectious.
  - ii. The Infection Control Nurse will review the source resident’s chart and interview the source resident and unit staff to determine who had a potential exposure. The Supervisor’s Airborne Transmissible Disease Exposure Report (Appendix E) will be used to collect surveillance data and determine exposures. Once completed a copy of this form will be faxed to DPH OSH and it will be provided to the LHH Industrial Hygienist and the exposed employee.
  - iii. Post-exposure medical evaluation shall occur as soon as feasible for employees who have had a significant exposure.

- iv. Employees will be referred to the ~~SFGH~~OHS clinic for post exposure treatment during normal working hours. ~~—~~ For exposures that occur during times when the ~~SFGH~~OHS clinic is closed, the employee's supervisor shall refer the employee to ZSFGH Urgent Care Clinic for medical evaluation.
- v. Employees who choose not to be evaluated by the ~~SFGH~~DPH OHS clinic or the ZSFG urgent care clinic may seek treatment at any of the Workers' Compensation Designated Clinics listed at <http://dphnet.dph.sf.ca.us/node/626> or their pre-designated provider.

d. The medical provider will provide Laguna Honda Employee Health with a written opinion limited to the following information:

~~e. The LHH Infection Control Nurse/Nurse Manager shall obtain and provide the employee a copy of the written opinion from the medical provider within 15 working days. The written opinion shall be limited to the following:~~

- i. Employee's TB test status or other ATD test status.
- ii. Employee's infectivity status.
- iii. A statement that the employee has been informed of the results and offered any applicable treatment.
- iv. A statement that the employee has been told about any medical conditions resulting from exposure and has been informed of treatment options.
- v. Any recommendations for precautionary removal from normal duties.

d.e. If the medical provider recommends temporary removal from work, the employee's manager shall code the employee's time away as paid administrative leave.

## **5. Procedures for Post-Exposure Communication of Disease Status of Exposure Source**

- a. The LHH Infection Control Nurse and Unit Nurse Manager shall communicate information regarding the disease status of the source resident to all affected LHH employees, students, family members, contractors and volunteers.
- b. The LHH Infection Control Nurse shall be responsible for reporting the source case or suspected case to the local health officer when required.
- c. The LHH Infection Control Nurse or designee will be responsible for reporting source cases or suspected cases to other employers such as paramedics,

contractors, acute hospital no longer than 72 hours after the report to the local health officer.

- d. The ~~LHH~~ notification to other employers shall include, date, time and nature of suspected exposure and any other pertinent information to help with surveillance. The identity of the source client shall not be provided to the other employer.

## 6. Procedures for Ensuring Adequate Supplies of PPE During Normal Operations and During a Medical Surge

- a. The Materials Manager is responsible for ensuring an adequate supply of PPE, including N95 respirators in Central Supply for use during normal operations.
- b. The LHH Medical Surge Plan can be found in the Emergency Response Manual (LHHPP 70-03 [Emergency Preparedness Committee](#) Appendix H5). If resources become limited during a medical surge, the Incident Commander will rely on the Logistics Section Chief in collaboration with the Safety Officer to develop a distribution plan customized for the specific product in short supply and the specific event. This may require re-use of PPE, including N95 respirators.
- c. If sufficient supplies cannot be obtained from suppliers even with rationing and re-use, the Incident Commander shall request additional resources from the SFDPH DOC.

## 7. Education and Training

- a. Training will be provided to all employees with the potential for an occupational exposure at the time of initial assignment to a job where occupational exposure may occur, at least annually thereafter, and whenever there are changes affecting exposures or control measures.
- b. ~~The LHH Industrial Hygienist~~ WSEM or ~~the DPH Occupational Safety and Health Section~~ OSH will develop the initial and annual ATD Training. ~~—~~ The training will be available to all LHH employees online through the educational computer program, Health-Stream. The exception to this will be training offered to CNA's and PCA's, which will be held in a traditional classroom setting.
- c. The LHH Department of Education and Training shall be responsible for making sure LHH staff complete the on-line training.
- d. Training programs shall include an opportunity for interactive questions and answers with a person knowledgeable in the subject matter. Training not given in person shall include contact information for the ~~LHH Industrial Hygienist~~ WSEM, the LHH Infection Control Nurse, and ~~the DPH OSH section~~ so that questions can be answered within 24 hours by a knowledgeable person.

## 8. Recordkeeping

- a. The Facility Services Department shall keep records of inspection, testing and maintenance of the All rooms.      These records shall be maintained for a minimum of 5 years and shall include the names and affiliations of the persons performing the test, inspection or maintenance, the date and any significant findings and actions that were taken.
- b. The Director of Education and Training shall maintain all ATD training records for at least three years from the date on which training occurred. The training records shall include the dates of the training session, the contents or a summary of the training session, the names and qualifications of persons conducting the training, the names and job titles of all persons attending the training sessions.
- c. LHH Employee Health shall maintain an accurate medical record for each employee with occupational exposure in accordance with Title 8 Section 3204, Access to Employee Exposure and Medical Records. The records shall include:
  - i. The employee's name and any other employee identifier used in the workplace.
  - ii. The employee's vaccination status for all vaccines required by this standard, any vaccination record provided by the employee, and any signed declination forms. In cases where seasonal influenza vaccination is declined, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.
  - iii. A copy of all written opinions provided by a medical provider in accordance with this standard, and the results of all TB assessments.
  - iv. A copy of the information regarding any exposure incident that was provided to a medical provider.
- d. The employer shall ensure that all employee medical records required by this section are:
  - i. Kept confidential and not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.
  - ii. The employer shall maintain the medical records required by this section for the duration of employment plus 30 years.

**ATTACHMENT:**

Appendix A: Aerosol Transmissible Diseases/Pathogens

(Original adoption: 15/03/10)

Appendix B: Job Classifications with Potential Occupational Exposure

(Original adoption: 15/03/10)

Appendix C: ATD Vaccinations Recommendations for Susceptible Health Care Workers

(Original adoption: 15/03/10)

Appendix D: Vaccination Declination Statements

(Original adoption: 15/03/10)

Appendix E: Supervisor's Airborne Transmissible Disease Exposure Report

(Original adoption: 15/03/10)

**REFERENCE:**

LHHPP 20-08 Use of Isolation Rooms

LHHPP 70-03 Emergency Response Plan: Appendix H5 Medical Surge Emergency Quick Reference Response Guide

LHHPP 72-01 Infection Control Manual: F2 Isolation Room Disinfection

LHHPP 72-01 Infection Control Manual: G2 Classification of Reusable Medical Devices and Processing Requirements

LHHPP 72-01 Infection Control Manual: ~~F12G3~~ Cleaning of Examination Rooms

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

LHHPP 73-09 Respiratory Protection Program (RPP)

LHHPP 73-12 Annual Employee PPD Testing

Cal/OSHA, Title 8, §3204, Access to Employee Exposure and Medical Records

CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005

Revised: 15/03/10, 16/11/08 (Year/Month/Day)

Original adoption: 12/09/25

## Appendix A: Aerosol Transmissible Diseases/Pathogens

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

### Diseases/Pathogens Requiring Airborne Infection Isolation

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g.  
 Anthrax/*Bacillus anthracis*  
 Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)  
 Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient.  
 Localized disease in immunocompromised patient until disseminated infection ruled out  
 Measles (rubeola)/Measles virus  
 Monkeypox/Monkeypox virus  
 Novel or unknown pathogens  
 Severe acute respiratory syndrome (SARS)  
 Smallpox (variola)/Variola virus  
 Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed;  
 Pulmonary or laryngeal disease, suspected  
 Any other disease for which public health guidelines recommend airborne infection isolation  
**\*residents diagnosed with these diseases/pathogens will require a negative pressure isolation room**

### Diseases/Pathogens Requiring Droplet Precautions

Diphtheria pharyngeal  
 Epiglottitis, due to *Haemophilus influenzae* type b  
*Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children  
 Influenza, human (typical seasonal variations)/influenza viruses  
 Meningitis  
*Haemophilus influenzae*, type b known or suspected  
*Neisseria meningitidis* (meningococcal) known or suspected  
 Meningococcal disease sepsis, pneumonia (see also meningitis)  
 Mumps (infectious parotitis)/Mumps virus  
 Mycoplasmal pneumonia  
 Parvovirus B19 infection (erythema infectiosum)  
 Pertussis (whooping cough)  
 Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,  
 Pneumonia  
 Adenovirus  
*Haemophilus influenzae* Serotype b, infants and children  
 Meningococcal  
*Mycoplasma, primary atypical*  
*Streptococcus Group A*  
 Pneumonic plague/*Yersinia pestis*  
 Rubella virus infection (German measles)/Rubella virus  
 Streptococcal disease (group A streptococcus)  
 Skin, wound or burn, Major  
 Pharyngitis in infants and young children  
 Pneumonia  
 Scarlet fever in infants and young children  
 Serious invasive disease  
 Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures). Any other disease for which public health guidelines recommend droplet precautions  
**\*residents with these diseases/pathogens do not require negative pressure in the isolation room**

## Appendix B: Job Classifications with Potential Occupational Exposure

Class	Title	Class	Title
<del>22302230</del>	<del>Physician Specialist</del>	<del>25562576</del>	<del>Physical Therapist Supv-Clinical Psychologist</del>
<del>22322232</del>	<del>Senior Physician Specialist</del>	<del>25582583</del>	<del>Senior Physical Therapist Home Health Aide</del>
<del>23022302</del>	<del>Nursing Assistant</del>	<del>25742587</del>	<del>Clinical Psychologist Health Worker III</del>
<del>23032303</del>	<del>Patient Care Assistant</del>	<del>25762588</del>	<del>Sprv Clinical Psychologist Health Worker IV</del>
<del>23122305</del>	<del>Licensed Vocational Nurse</del>	<del>25832589</del>	<del>Home Health Aide Health Program Coordinator I</del>
<del>23202342</del>	<del>Registered Nurse</del>	<del>25872593</del>	<del>Health Worker 3 Health Program Coordinator III</del>
<del>23222320</del>	<del>Nurse Manager</del>	<del>25882624</del>	<del>Health Worker 4 Dietician</del>
<del>23232322</del>	<del>Clinical Nurse Specialist</del>	<del>27362626</del>	<del>Porter Chief Dietician</del>
<del>23242323</del>	<del>Nursing Supervisor</del>	<del>29202736</del>	<del>Medical Social Worker Porter</del>
<del>23262324</del>	<del>Nursing Supervisor</del>	<del>29222738</del>	<del>Senior Medical Social Worker Porter Assistant Supervisor</del>
<del>24242424</del>	<del>X-Ray Laboratory Aide</del>	<del>29242740</del>	<del>Medical Social Work Supervisor Porter Supervisor I</del>
<del>24302430</del>	<del>Medical Evaluations Assistant</del>	<del>29302785</del>	<del>Psychiatric Social Worker Assistant General Services Mgr</del>
<del>24542454</del>	<del>Clinical Pharmacist</del>	<del>29312903</del>	<del>Marriage, Family &amp; Child Cnslr Eligibility Worker</del>
<del>25362468</del>	<del>Respiratory Care Practitioner</del>	<del>61382908</del>	<del>Industrial Hygienist Hospital Eligibility Worker</del>
<del>25422469</del>	<del>Speech Pathologist</del>	<del>61392909</del>	<del>Senior Industrial Hygienist Hospital Eligibility Supervisor</del>
<del>25482536</del>	<del>Occupational Therapist</del>	<del>73342920</del>	<del>Stationary Engineer Medical Social Worker</del>
<del>25502537</del>	<del>Senior Occupational Therapist</del>	<del>73352922</del>	<del>Senior Stationary Engineer Sr Medical Social Worker</del>
<del>25542542</del>	<del>Therapy Aide</del>	<del>P1032924</del>	<del>Special Nurse Medical Social Worker Supv</del>
<del>25552548</del>	<del>Physical Therapist Assistant</del>	<del>2930</del>	<del>Psychiatric Social Worker</del>
<del>2550</del>	<del>Sr Occupational Therapist</del>	<del>6138</del>	<del>Industrial Hygienist</del>
<del>2554</del>	<del>Therapy Aide</del>	<del>7205</del>	<del>Chief Stationary Engineer</del>
<del>2555</del>	<del>Physical Therapist Assistant</del>	<del>7334</del>	<del>Stationary Engineer</del>
<del>2556</del>	<del>Physical Therapist</del>	<del>7335</del>	<del>Sr. Stationary Engineer</del>
<del>2558</del>	<del>Senior Physical Therapist</del>	<del>7524</del>	<del>Institution Utility Worker</del>
<del>2574</del>	<del>Clinical Psychologist</del>	<del>P403</del>	<del>Special Nurse</del>

## Appendix C: ATD Vaccination Recommendations for Susceptible Health Care Workers

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses

Source: California Department of Public Health, Immunization Branch



## Appendix D: Vaccination Declination Statements

### ***General Vaccination Declination Statement***

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with \_\_\_\_\_ (name of disease or pathogen). I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring \_\_\_\_\_, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

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

\_\_\_\_\_  
Date

### ***Seasonal Influenza Vaccination Declination Statement***

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

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

\_\_\_\_\_  
Date

## Appendix E: Supervisor's Airborne Transmissible Disease Exposure Report

The Supervisor/Nurse Manager must complete this form when there is an alleged or suspected worker exposure to an airborne transmissible disease. The supervisor should give a copy to the potentially exposed employees to take with them when they seek medical services. The form must be immediately faxed to the OSH Section at 554-2570.

<b>1. DPH/Division:</b>		
<input type="checkbox"/> San Francisco General Hospital	<input type="checkbox"/> Community Health Programs	<input type="checkbox"/> Jail Health Services
<input type="checkbox"/> Laguna Honda Hospital	<input type="checkbox"/> Community Health & Safety	<input type="checkbox"/> Primary Care
		<input type="checkbox"/> Central Administration
		<input type="checkbox"/> Other _____
<b>2. Source Patient Diagnosis</b>		
<input type="checkbox"/> Aerosolizable spore-containing powder	<input type="checkbox"/> Novel or Unknown Pathogens	
<input type="checkbox"/> Avian Influenza	<input type="checkbox"/> Pertussis (whooping cough)	
<input type="checkbox"/> Diphtheria pharyngeal	<input type="checkbox"/> Pneumonic plague	
<input type="checkbox"/> Haemophilus influenzae	<input type="checkbox"/> Rubella virus infection	
<input type="checkbox"/> Measles (rubeola)/Measles virus	<input type="checkbox"/> Severe acute respiratory syndrome (SARS)	
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Smallpox (variola) Variola virus	
<input type="checkbox"/> Meningococcal disease sepsis	<input type="checkbox"/> Tuberculosis (TB)	
<input type="checkbox"/> Monkeypox	<input type="checkbox"/> Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	
<input type="checkbox"/> Mumps		
<input type="checkbox"/> Other disease for which public health guidelines recommend airborne infection isolation. Please Specify:		
<b>3. Exposure source patient (First, Last, MI)</b>	<b>4. Location of Contact</b>	<b>5. Incident Date and Time</b>
		AM/PM
<b>6. Date Source Pt. presented</b>	<b>7. Laboratory Confirmed Diagnosis</b> <input type="checkbox"/> Yes-- <input type="checkbox"/> No	<b>8. Date of Diagnosis</b>
<b>9. Were Isolation Procedures Employed? Please Describe</b>		<b>10. If isolation procedures were not employed, please explain:</b>
<b>11. Was patient masked?</b> <input type="checkbox"/> Yes-- <input type="checkbox"/> No	<b>12. Describe nature of unprotected contact</b>	<b>13. Duration of unprotected contact</b>
<b>14. Were aerosol generating procedures (e.g., sputum, induction, aerosolized administration of medications, etc.) performed during the exposure incident? If yes please explain:</b>		
<b>15. Was all appropriate Personal Protective Equipment (PPE) used? If not, explain why:</b>		
<b>16. Were employees of any other employer involved? If so, list employer and potentially exposed employees:</b>		
<b>17. In your opinion, what could have been done to prevent this exposure incident? Please explain:</b>		
<b>18. Supervisor's signature:</b> _____		<b>19. Supervisor's phone number:</b>
<b>Date:</b>		

**21. Potentially exposed employees:**

Name (Last, First, MI)	Job Class #	Emp Phone #	Exposure Description	PPE Used
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____
				<input type="checkbox"/> N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Eye <input type="checkbox"/> Mask <input type="checkbox"/> Gown    Protection <input type="checkbox"/> Other _____

**22. Supervisor's signature:**

**23. Supervisor's phone number:**

**24. Date:**

## DISORDERLY OR DISRUPTIVE VISITORS

### POLICY:

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

### PURPOSE:

To provide safety and security for everyone on premises.

### PROCEDURE:

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

- f. Danger, are there any weapons involved.
- g. REMAIN ON THE LINE.

If a weapon is brandished, or the situation poses potential risk of harm, call “Dr. Grey”

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

If the visitor has been asked to leave and if the visitor refuses, and all efforts to encourage that person to leave voluntarily fail, the Deputy may choose to charge the person with violating trespassing on hospital grounds.

- 6. The ~~Sheriff's-SFSD~~ Watch Commander may recommend that problematic persons be prohibited from entering the hospital. This information ~~will~~ shall be submitted to the Executive Administrator, or designee.
- 7. Visitors with aggressive behaviors, may have restrictions placed upon their visits to the facility.
- 8. The Deputy City Attorney may be contacted for consideration of a stay away order or a restraining order.

**ATTACHMENT:**

None.

**REFERENCES:**

LHHPP 75-06 Dr. Grey Code  
SFSD Response Template Calls for Service

Revised: 96/07/15, 10/06/08. 15/09/08, 16/11/08 (Year/Month/Day)  
Original adoption: 94/08/15

## 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~~ shall 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~~ shall 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~~ shall support the neighborhood's nursing staff, when advising visitors of the necessary precautions.

2.4 The Nursing Office/Neighborhood Resident Care Team ~~will~~ shall address special considerations to visitors for residents/patients with visiting restrictions.

2.4.1 Visitation restrictions or prohibition ~~will~~ shall 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 LHHPP 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 Recommended visiting hours are daily, from 10:00 a.m. to 9:00 p.m. ~~Regular visiting hours are daily, from 10:00 AM – 9:00 PM.~~

## 5.0 Visitor Screening and Authorization

5.1 The department staff/manager or resident neighborhood staff/care team ~~will~~shall inform ahead of time the contract security provider of planned visitors to their department/neighborhood, and if feasible ~~will~~provide a list of visitors to the contract security provider.

5.2 The neighborhood staff/care team ~~will~~shall also inform the contract security provider of visitor restrictions as applicable.

5.3 Upon the visitor signing in, the contract security provider's staff ~~will~~shall determine the neighborhood/department that the person will ~~be~~ visiting and/or call for authorization as applicable.

5.4 The floor/department providing authorization ~~will~~shall inform the contract security provider's staff if:

5.4.1 the visitor can walk directly to the floor/department or

5.4.2 request the contract security provider staff to have the visitor wait at the lobby for the department staff to come meet the visitor.

5.5 If authorization is granted, using the visitors pass kiosk, the officer ~~will~~shall issue a visitor's pass.

~~5.3 The contract security provider's staff will determine the floor/department that the person will visit and call for authorization as required.~~

~~5.3.1 If authorization is granted, using the visitors pass kiosk, the officer will issue a visitor's pass.~~

~~5.3.2 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.~~

~~5.3.3 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

<b>DATE:</b>	<b>SECURITY REPRESENTATIVE:</b>	<b>POSITION:</b>





## NURSING MANAGEMENT OF URINARY CATHETERS

### POLICY:

1. Licensed Nurse will consult with physician regarding alternatives to an indwelling urinary catheter (e.g., condom catheter, intermittent catheterization, bladder emptying dysfunction, neurogenic bladder). Urinary catheters should not be used in residents ~~solely~~ solely for the management of incontinence.
2. Urinary catheters will only be utilized for appropriate indications, and left in place only as long as needed.
  - a. Examples of appropriate indications include; Acute urinary retention or bladder outlet obstruction, need for accurate measurements of urinary output, to assist in healing of open sacral or perineal wounds in incontinent patients, patients requiring prolonged immobilization, to improve comfort for end of life care if needed.
3. In the non-acute setting, clean (i.e., non-sterile) technique for intermittent catheterization is an acceptable and more practical alternative to sterile technique for residents requiring chronic intermittent catheterization.
4. Urinary catheters require a written physician's order, and can only be inserted by Licensed Nurses.
5. Licensed Nurses assess indwelling urinary catheters for any blockage, obstruction, or leakage, and monitor residents for any signs and symptoms of catheter-associated urinary infections (CAUTI). Assessment findings, appropriate interventions, and evaluation must be documented.
6. Routine catheter irrigation is contraindicated unless there is a written order from the physician.
7. Aseptic technique is observed and use sterile equipments at all times when inserting or replacing an indwelling or intermittent catheter to prevent infection. Clean technique is observed on routine indwelling catheter care.
8. Licensed Nurse or nursing assistants perform daily urinary catheter care.
9. Indwelling catheter and drainage bags will be changed base on clinical indication such as infection, obstruction, or when the closed system is compromised.
10. Any nursing staff member may apply or remove a leg bag using standard precautions.
- 10-11. Intake and output will be measured every shift for residents with urinary catheter.

### PURPOSE:

To minimize the risk of CAUTI.

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### PROCEDURE:

#### A. Equipment

## **Nursing Management of Urinary Catheters**

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Non-sterile gloves and additional personal protective equipment if needed  
Drape or blanket  
Urinary Catheter (Indwelling or Straight)  
Urinary Catheter Insertion Tray  
Closed-System Urinary Drainage Bag  
Flash light (as needed)

### **B. Preparations for Inserting Intermittent and Indwelling Urinary Catheter**

1. Check for physician order and indication. If indication is not included in the order contact physician.
2. Review the manufacturer's instructions for the type of urinary catheter to be used, and how much balloon volume is needed.
3. Unless otherwise clinically indicated, consider using the smallest bore catheter possible, consistent with good drainage, to minimize bladder neck and urethral trauma.
4. Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.
5. Explain the procedure to the resident.
6. See Appendix 1 for procedure for indwelling and straight catheter insertion for both female and male resident.

### **C. Proper Techniques for Urinary Catheter Maintenance**

1. Following aseptic insertion of the urinary catheter, maintain a closed draining system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment.
2. Maintain unobstructed urine flow.
  - a. Keep the catheter and collection tube free from kinking.
  - b. Keep the collecting bag below the level of the bladder at all times.
  - c. Do not rest the collecting bag on the floor.
  - d. Use aseptic technique when changing the drainage bag to reduce risk of infection. Utilize clean technique by washing hands and wearing non-sterile gloves when emptying the drainage bag.
  - e. Empty the collecting bag regularly, using a separate, clean collecting container for each resident.
3. Monitor resident for adequate urinary output every 8 hours or as indicated.
4. Provide on-going assessment of urine drainage, noting any residue, sediment, foul odor, cloudiness, or blood.
5. Perform daily routine urinary catheter care:

## **Nursing Management of Urinary Catheters**

- a. Female resident: Clean the urinary meatus with routine hygiene products from the base of the catheter, moving up and away from the insertion site. If necessary, continue to wash the rest of the perineal and anal area from front to back. Dry skin with towel.
  - b. Male resident: Retract foreskin, if present, away from the catheter. Clean around the urinary meatus with routine hygiene products. Dry skin with towel. Gently pull foreskin, if present, back around the catheter. Continue to clean between the scrotum and anus with a separate washcloth and dry the area.
6. Empty the drainage bag at least when bag is two-thirds full. Then clean the drainage bag outlet with routine hygiene products after emptying the drainage bag.
  7. May use cloth bag to cover drainage bag when resident is out of his/her bed. Do not attach the drainage bag to the bedrails to prevent potential pulling of the catheter or bag when bedrails are adjusted.
  8. Verify that the catheter and tubing are secured to the resident's inner thigh using the facility-approved catheter tube stabilization device. Ensure the draining tube is not kinked, or too loose or tight to allow resident to move freely.
  9. Unless obstruction is anticipated, bladder irrigation is not recommended.
  10. If using a urinary leg bag, refer to Appendix 2 (Application of Urinary Leg Bag). The leg bag for urinary collection is discarded after a single use or when visibly soiled. To prevent backflow and possible microbial contamination, leg bag is placed below the level of the bladder and tubing draped above bag and leg bags are not used when the resident is in bed.

### **D. Urinary Catheter Care Maintenance for Aquatic Services**

#### **1. Perform hand hygiene and apply clean gloves.**

#### **2. Empty the drainage bag completely.**

~~**Disconnect drainage bag from the urinary catheter and discard.**~~

#### **3. Obtain a catheter plug with cap from Central Supply. ~~disconnect drainage bag from the urinary catheter and discard and cap the end of urinary catheter to prevent urine backflow and to stop drainage.~~**

#### **4. Conceal catheter tubing inside resident's swimsuit/swim trunk.**

#### **5. After aquatics therapy and return to the unit, reconnect to a new drainage bag using aseptic technique.**

### **D.E. Documentation**

1. The physician order should include the indication and duration of use, specifies size of the catheter, type of the indwelling or suprapubic catheter, balloon volume, routine indwelling

## Nursing Management of Urinary Catheters

catheter care, interventions when obstruction is encountered, and discontinuation of the indwelling catheter.

### 2. Integrated Progress Notes

- a. Document on initial insertion:
  - i. Date and time of indwelling catheter inserted, including the size of the catheter and volume of balloon inflated.
  - ii. Volume and any untoward events encountered during the procedure and urine characteristics (i.e. color, clarity, odor, presence of sediment or clots)
  - iii. Resident's tolerance of the procedure.
  - iv. If urine specimen was sent to the laboratory.
- b. Documentation for daily, weekly, or monthly summary:
  - i. Any unexpected events encountered during the specific period such as obstruction or leakage, bladder distention, change in urine output from baseline, clinical signs and symptoms that may indicate infection or other complications.
  - ii. Any interventions performed and evaluation and outcome of intervention.
  - iii. Record any problems to the licensed nurse if resident is having problems with leg bag e.g. leakage, skin irritation etc.

### 3. Treatment Administration Record (TAR)

- a. Initial TAR when changing close-system drainage bag.
- b. Document intake output, ~~if measured~~.

### 4. Resident Care Plan (RCP)

- a. Front Card: Document the initial date of insertion, type and size of the indwelling catheter used, any unique management or approaches to resident when inserting catheter.
- b. RCP: Address possible risk for complications and infections related to use of indwelling catheter, measurable goals and date, and interventions. On-going problems should be addressed and documented in the Integrated Progress Notes as indicated. RCP goals are reviewed and updated accordingly.
- b-c. For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the RCP.

## APPENDICES:

Appendix 1 - Procedures in Inserting Urinary Catheter for Male and Female Resident  
Appendix 2 – Application of Urinary Leg Bag

## REFERENCES:

Healthcare Infection Control Practices Advisory Committee (2009). Guideline for prevention of catheter-associated urinary tract infections. Accessed at <http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf>

**Nursing Management of Urinary Catheters**

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<http://web.ebscohost.com/nrc/detail?sid=3c7625bb-06f4-4997-88c2-7e0d493d3995%40sessionmgr198&vid=1&hid=108&bdata=JnNpdGU9bnJlLWxpdmU%3d#db=nrc&AN=T705086> – accessed on 10/11/2013

<http://web.ebscohost.com/nrc/detail?sid=8de2f0b8-d3b5-43cc-a6f6-7a091455187a%40sessionmgr111&vid=1&hid=108&bdata=JnNpdGU9bnJlLWxpdmU%3d#db=nrc&AN=T704779> - accessed on 10/11/2013

**CROSS REFERENCE:**

NPP G 3.0 Intake and Output

Revised: 04/2006; 05/27/2014; 03/10/2015

Reviewed: 03/10/2015~~05/27/2014~~

Approved: 03/10/2015\_\_\_\_\_

## APPENDIX 1 - Procedures in Inserting Urinary Catheter for Male and Female Resident

1. Gathers and brings the equipment needed for the procedure to the resident's bedside:
  - a. Indwelling Catheter
    - i. Catheter insertion tray
    - ii. Foley Catheter (size based on MD order)
    - iii. Drainage Bag
  - b. Straight Catheter
    - i. Urethral catheter tray
  - c. Flash light
2. Explains procedure to the resident.
3. Positions the resident as follows:
  - a. Female: Dorsal recumbent position (on back with knees flexed), have resident relax the thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip.
  - b. Male: Supine position with legs extended and thighs slightly abducted
4. Covers or drapes the resident with blanket so that only perineum or genitals are exposed.
5. Positions light to illuminate perineum or have someone assists in holding the flashlight to visualize urinary meatus.
6. Performs hand hygiene.
7. Preparation of equipment needed:
  - a. Places unopened catheter insertion tray, foley catheter, and drainage bag on a clean surface close to the resident.
  - b. Opens the outer wrapper of the catheter tray using sterile technique.
  - c. Opens the package of the drainage bag, checks to see if drainage bag clamp is closed, and sets bag aside.
  - d. Opens the outer wrapper of the foley catheter while maintaining sterility of the inner wrapper and places catheter together with the opened, sterile catheter insertion tray.
  - e. Puts on sterile gloves.
  - f. Places absorbent pad (shiny-side down) under the buttocks while keeping gloves sterile. Drapes resident's perineum. For females, expose labia. For males, expose penis.
  - g. Arranges the supplies on the sterile field.
  - h. Tests integrity of the catheter's balloon based on the manufacturer's recommendations. Using the pre-filled syringe, inflate the balloon to its maximum balloon capacity; withdraw solution if no leakage. Keep the pre-filled syringe attached to the catheter.
  - i. Lubricates catheter with sterile lubricating jelly 1 to 2 inches for female residents and 5 to 7 inches for male residents.
  - j. Pours the aseptic solution (Povidone-Iodine) over the cotton balls.

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8. Cleanses urinary meatus with antiseptic solution

a. Female:

- i. Using the non-dominant hand (non-sterile hand) separate the labia with fingers to fully expose the urinary meatus. This hand should maintain this position for the remainder of the procedure.
- ii. Using the sterile hand, use forceps to hold the pre-moistened cotton balls.
- iii. 1<sup>st</sup> pre-moistened cotton ball: clean along side farthest from the nurse along the meatus in a single stroke, discard the 1<sup>st</sup> cotton ball.
- iv. 2<sup>nd</sup> pre-moistened cotton ball: clean labia and meatus nearest the nurse using a single stroke, discard the 2<sup>nd</sup> cotton ball.
- v. 3<sup>rd</sup> pre-moistened cotton ball: clean the midline, directly over the meatus; then discard the 3<sup>rd</sup> cotton ball.
- vi. Using the sterile gloved hand, holds the catheter 3-4 inches from the tip. Holds the end of the catheter loosely and coils in the palm of the dominant hand.

b. Male:

- i. Using the dominant hand (non-sterile hand) retract foreskin (if uncircumcised) and grasp the penis at shaft just below the glans. This hand should maintain this position for the remainder of the procedure.
- ii. Hold shaft of the penis at right angle to the body.
- iii. Using the sterile hand, use forceps to hold the pre-moistened cotton balls.
- iv. Cleanse the meatus in circular strokes, beginning at the meatus and working outwards in a spiral motion. Repeat with three cotton balls (one at a time); discard each cotton ball after each use.
- v. Using the sterile gloved hand, holds the catheter 3-4 inches from the tip. Holds the end of the catheter loosely and coils in the palm of the dominant hand.

9. Catheter insertion

a. Female:

- i. Instructs resident to bear down gently and insert catheter.
- ii. Advances catheter slowly a total of 2 to 3 inches or until urine flows out catheter's end.
- iii. Once urine appears, advances the catheter another 1 – 2 inches. Do not force if resistance is encountered.
- iv. Releases labia and holds catheter securely using the non-dominant hand

b. Male:

- i. Applies gently upward traction to the penis using the non-dominant hand
- ii. Instructs resident to bear down gently and insert catheter through the meatus.
- iii. Advances catheter about 7 – 9 inches or until urine flows out at the end of the catheter.
- iv. When urine appears, advances catheter to bifurcation of drainage and balloon inflation port. Do not force catheter insertion.
- v. Lowers penis and holds catheter securely using the non-dominant hand.

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10. Inflating the balloon catheter

- a. Allows bladder to empty fully unless contraindicated.
- b. Collects urine as needed.
- c. Keeps the non-dominant hand securely holding the catheter.
- d. Using the dominant hand,
  - i. Attaches the pre-filled syringe in the injection port at the end of the catheter.
  - ii. Slowly injects the designated amount of fluid to inflate the balloon. If resident complains of sudden pain, stop injection and gently withdraw fluid from balloon, advance the catheter further and re-inflate the balloon.
  - iii. After inflating the catheter balloon, releases catheter from the non-dominant hand.
- e. Gently pulls the catheter until resistance is felt, then advance slightly.
- f. Attaches the catheter to drainage bag.

11. Securing indwelling catheter with tape

- a. Female: Secures catheter to inner thigh with tape or catheter strap, allowing slack to prevent tension.
- b. Male: Secures to lower abdomen with tape or catheter strap. If retracted, replace foreskin over the penis glans.
- c. Positions drainage bag lower than the bladder by attaching the bag to the bed frame. Do not attach to the side rails of the bed.



## APPENDIX 2 – Application of Urinary Leg Bag

1. Application of Leg Bag
  - a. Make sure the condom is not twisted where it attaches to the catheter.
  - b. Position the leg bag to prevent pulling on the catheter tubing and position resident preference and comfort.
  - c. Maintain the leg bag at a position that promotes urine flowing downward.
  - d. To prevent backflow and possible microbial contamination, leg bag is placed below the level of the bladder and tubing draped above bag and leg bags are not used when the resident is in bed.

## **REPLACEMENT AND CARE/MAINTENANCE OF AN EXISTING SUPRAPUBIC CATHETER**

### **POLICY:**

1. Suprapubic (SP) catheters are changed on a quarterly basis, unless otherwise specified by the physician order, by the Registered Nurse (RN) to prevent clogging of the catheter and to aid in the prevention of catheter acquired urinary tract infections (CAUTI).
2. Initial replacement of a SP catheter is performed by a physician. Thereafter, only a RN with demonstrated competency of SP catheter insertion may replace the existing SP catheter, with a physician order specifying the catheter type, size, balloon volume, type of dressing, and indication for the catheter.
3. The Licensed Nurse will provide site care of an existing SP catheter daily and as needed.
4. All SP catheters must be secured to the abdomen with an anchoring device to prevent accidental removal.
5. For additional applicable policy statements, refer to the Nursing Policy and Procedure, F5.0 Nursing Management of Urinary Catheters.

### **PURPOSE:**

To prevent CAUTI, to maintain SP catheter patency, and to provide a guide for safe aseptic replacement of an existing SP catheter.

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### **Background:**

SP catheters are used when urethral catheterization is not possible or desirable due to; urethral stricture, prostatic enlargement, urethral trauma, postoperative drainage after lower urinary tract or bowel surgery, and the management of neurogenic bladder. Residents with neurologic conditions such as multiple sclerosis, spinal cord injury, or other, may choose the use of a SP catheter to simplify their long-term catheter management and reduce urethral trauma due to the need for repeated urethral catheterizations (Lamont, et. al, 2011). These catheters are also changed for catheter blockage and leakage around the catheter (usually a sign of impending blockage).

### **PROCEDURE FOR REPLACEMENT OF SP CATHETER:**

#### **A. Equipment**

1. Clean gloves
2. Sterile gloves
3. Two (2) 12mL syringes;
  - a. One syringe to deflate balloon
  - b. One syringe filled with 10mL (or other volume as specified by physician order) of sterile water for replacement SP catheter balloon inflation
4. Catheter tray (comparable-sized catheter to size resident has currently, unless ordered otherwise)
5. Three (3) 4x4s
6. New leg bag or bedside bag
7. Irrigation set
8. 250 mL of normal saline

9. Water soluble lubricant
10. Catheter anchoring device

#### **B. Replacement of an existing SP Catheter**

1. Perform hand hygiene; apply clean gloves.
2. Inspect the SP catheter where it enters the suprapubic tract (stoma) for encrusted material or drainage. Also inspect the tissue around the catheter.
3. Using a cleansing/hygiene product, cleanse gently around the SP catheter, working outward. Remove all exudate and dry completely.
4. Place 4x4s near the site to catch any urine leakage when the existing SP catheter is removed.
5. Instill 30mL normal saline into the established catheter prior to removing the catheter. This will establish patency when the new SP catheter is inserted.
6. Gently deflate the balloon of the existing SP catheter with the appropriate size syringe.
7. Remove catheter by gently pulling it straight out in a slow steady manner. Note the approximate length of the SP catheter. This will assist in estimating the length when inserting the replacement SP catheter.
  - a. If the SP catheter cannot be withdrawn easily, notify the physician.
8. Remove gloves, use hand sanitizer before applying sterile gloves.
9. Immediately apply 5mL to 10mL of water-soluble lubricant onto the suprapubic tract (stoma) and insert new SP catheter.
10. Once urine returns, insert the SP catheter approximately 2 inches further to ensure the SP catheter is in the bladder and not the suprapubic tract.
  - a. If urine flow does not occur within a minute or so of SP catheter insertion, use a syringe and irrigate, freeing the SP catheter lumen of the lubricant.
11. Inflate the balloon with prescribed amount of sterile water and attach the SP catheter to the appropriate drainage system.
12. Apply dressing per MD order.
  - a. Established sites (5-7 days) that are not draining may not require a dressing.
13. Secure catheter to resident's abdomen with catheter anchoring device, approximately 6-8 cm from insertion site. Do not pull catheter taut and allow enough room to insert 2 fingers under the catheter.

#### **C. DOCUMENTATION**

1. Document date and time of SP catheter change, size of SP catheter, amount of sterile water in balloon, note ease of removal of previous SP catheter, condition of site, type of dressing applied, and resident's tolerance of procedure, on the Treatment Administration Record (TAR).

#### **PROCEDURE FOR CARE OF AN EXISTING SP CATHETER:**

##### **A. Equipment**

1. Clean gloves
2. Washcloth or gauze
3. Usual cleansing/hygiene product
4. 4x4 dressing or other dressing as specified in MD order
- 4-5. [Catheter plug with cap for aquatics therapy](#)

##### **B. Care and Maintenance of an Existing SP Catheter**

1. Perform hand hygiene.
2. Apply clean gloves.
3. Daily, and as needed, cleanse exit site gently with washcloth using warm water and usual cleansing product. Use a circular motion starting at the SP catheter exit site and going outward.

4. Dry completely.
5. Inspect for signs of infection (redness, exudate, and swelling) and signs of urine leakage.
6. Apply daily dressing as ordered.
7. Check that the drainage bag is secured to the SP catheter.
8. Ensure that the SP catheter is secured to resident's abdomen with a catheter anchoring device, approximately 6-8 cm from insertion site. Do not pull catheter taut and allow enough room to insert 2 fingers under the catheter.
9. For applicable routine maintenance of an indwelling urinary catheter, refer to Nursing Policy and Procedure, F5.0 Nursing Management of Urinary Catheters.

### **C. SUPRAPUBIC CATHETER MAINTENANCE FOR AQUATIC SERVICES**

1. Perform hand hygiene and apply clean gloves.  
—Empty the drainage bag completely.
2. Disconnect drainage bag from the SP catheter and discard.
3. Obtain a catheter plug with cap from Central Supply, disconnect drainage bag from the SP catheter and discard and cap the end of SP catheter to prevent urine backflow and to stop drainage.
4. Conceal catheter tubing inside resident's swimsuit/swim trunk.
5. After aquatics therapy and return to the unit, reconnect to a new drainage bag using aseptic technique.

### **G.D. DOCUMENTATION**

1. Document dressing change on the Treatment Administration Record (TAR) and document pertinent observations of catheter insertion site in the Integrated Progress Notes.

### **REFERENCES:**

Society of Urologic Nurses and Associates/SUNA (2005). Clinical practice guidelines: Suprapubic catheter replacement.

Healthcare Infection Control Practices Advisory Committee (2009). Guideline for prevention of catheter-associated urinary tract infections. Accessed at:

<http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf>

Lamont, T., Harrison, S., Panesar, S., & Surkitt-Parr, M. (2011). Safer insertion of suprapubic catheters: Summary of a safety report from the national patient safety agency. *BMJ*, 342, 546-548.

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### **CROSS REFERENCE:**

NPP F5.0 Nursing Management of Urinary Catheters

Revised: 05/27/2014

Reviewed: 05/27/2014

Approved: 05/27/2014

POLICY AND PROCEDURE FOR EXPIRATION DATING OF PHARMACEUTICALS

**Policy:**

Pharmaceutical products dispensed by the pharmacy shall be labeled with beyond-use dates. These dates will be indicative of the date after which the prescription drug may not be used. This date shall be used as information on when a product should be discarded or returned to the pharmacy to be discarded. Pharmaceutical products shall not be dispensed after the expiration date on the manufacturer's container.

**Purpose:**

To comply with legal requirements and good clinical practice.

**Procedure:**

A. Repackaged unit-dose or single-unit containers:  
See 02.01.09

B. Multiple-unit container (e.g. typical prescription vial):  
The beyond-use dates for multiple-unit containers, such as a typical prescription vial, are not later than a) the expiration date on the manufacturer's container or b) one year from the date the drug is dispensed, **whichever is earlier**.

~~C. C. Compounded Items:~~

~~1. Non sterile compounding see 02.01.08~~

~~2. Sterile compounding see 07.00.00~~

~~1. Mixed creams or ointments (one cream/ointment folded into another cream/ointment): The expiration date given shall be the manufacturer's expiration date of the product with the shorter expiration, providing the two compounds are compatible.~~

~~2. Dakin's Solution: When compounded by the Pharmacy, the expiration date shall be 30 days from the date of compounding when stored at room temperature. If commercially available, the expiration date shall be per the manufacturer's labeling.~~

~~3. 10% Bleach in water: The expiration date shall be 30 days from the date of \_\_\_\_\_ compounding when stored at room temperature.~~

~~4. Sodium Chloride 1g/5ml solution: The expiration date shall be 30 days from the date of compounding.~~

~~5. Amphotericin B (0.1mg/ml) mouthwash: The expiration date shall be 1 week from the date of compounding when stored in the refrigerator.~~

- ~~6. LCD 10% in Aquaphor with Betamethasone Dip 0.05% (1:1): The expiration date shall be 6 months from the date of compounding.~~
- ~~7. "UC Mouthwash": The expiration date shall be 30 days from the date of compounding when stored in the refrigerator.~~
- ~~8. Other compounded items: the pharmacist as per standard references or standard pharmacy practices shall assign the expiration date.~~

D. ~~Multi-dose Vials of~~ Injectable Drugs

1. Multidose vials of injectables contain preservative

a) shall be:

- (1) dated upon initial entry
- (2) refrigerated for stability, if recommended by the manufacturer (open insulin vials may be stored in individual resident cassettes)

shall be visually inspected prior to use and discarded if any of the following occur:

(3)

- (a) there is a change in appearance of the solution
- (b) there is damage or loss of integrity of the closure
- ~~(a) the drug has been improperly stored~~
- (c)
- (d) the vial is known or suspected to be contaminated
- (4) discarded within 28 days after initially entering or opening or after 72 hours if Interlink System Vial Adapter is used on the drug vial.

~~(b)(a) shall be visually inspected prior to use and discarded if any of the following occur:~~

~~there is a change in appearance of the solution~~  
~~there is damage or loss of integrity of the closure~~  
~~the drug has been improperly stored~~  
~~the vial is known or suspected to be contaminated~~

~~(2)~~

2. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.
3. PPD vials shall be dated upon initial entry, refrigerated, and discarded after ~~30~~28 days.
4. Insulin vials shall be dated upon initial entry. Open vials may be kept in individual resident cassettes or in the refrigerator. Open, in-use vials shall be discarded after 28 days. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

5. Injectables that contain preservatives shall be:

~~\_\_\_\_\_ (a) dated upon initial entry~~

~~(b) refrigerated for stability, if recommended by the manufacturer (open insulin vials may be stored in individual resident cassettes)~~

~~(c) discarded within 28 days after initially entering or opening or after 72 hours if Interlink System Vial Adapter is used on the drug vial.~~Intravenous fluids

When the intravenous fluid overwrap is torn or removed any bags that are not used immediately will be dated with a sticker (obtained via central supply). The dating will be 15 days for 25 and 50 ml bags and 30 days for intravenous fluids 100 ml or larger.

New: 6/97SK/BT

Revised: 5/15/98SK, 8/01DY, 2/02DY, 4/03 DW, 12/08dw, 9/16

Reviewed: 2/06, 01/08, 04/09, 2/10, 5/11



**MEDICATIONS/ DEVICES♦ WITH SPECIAL EXPIRATION DATE REQUIREMENTS**

Item:	Expires:
Accu-Chek® Blood Glucose Test Strips	Good until manufacturer's expiration date
Blood Glucose Testing Control Solutions	90 days after opening
Dakins Solution	If compounded by LHH pharmacy, expires 3 days after opening
Dakins Solution	If from Century Pharmaceuticals, good until the manufacturer's expiration date (see expiration date sticker on bottom of bottle)
Insulins ( <i>refrigerate unopened vials, open vials may be stored in individual resident cassettes</i> )	28 days after opening
Interlink® System Vial Adapter♦	The multi-dose vial is good for 72 hours after the vial adapter is snapped on.
Ioprep Solution	3 days after opening
Irrigation Solutions(Acetic acid, NS irrigation, Irrigation G, Sterile Water)	24 hours after opening
<u>Intravenous Fluids removed from overwrap</u>	<u>25-50 ml 15 days</u> <u>100 ml or larger 30 days</u>
Miacalcin Nasal Spray	30 days once assembled, store upright
Multiple Dose Vials	28 days after opening
Nitroglycerin Sublingual Tablets	6 months after opening
Phospholine Iodide Eye Drops	4 weeks after dispensing at room temp
PPD (Aplisol or Tubersol) ( <i>refrigerate</i> )	28 days after opening
Roxanol Oral Solution	90 days after opening
Xalatan Eye Drops	6 weeks after opening

All of the above items must be dated when opened. The potency of these medications when unopened is maintained up to the expiration date on the container when stored appropriately.

New: 2/02 DY

Revised: 4/03 DW, 03/06DW, 12/08dw, 09/16

Reviewed: 2/06, 02/08, 04/09, 2/10